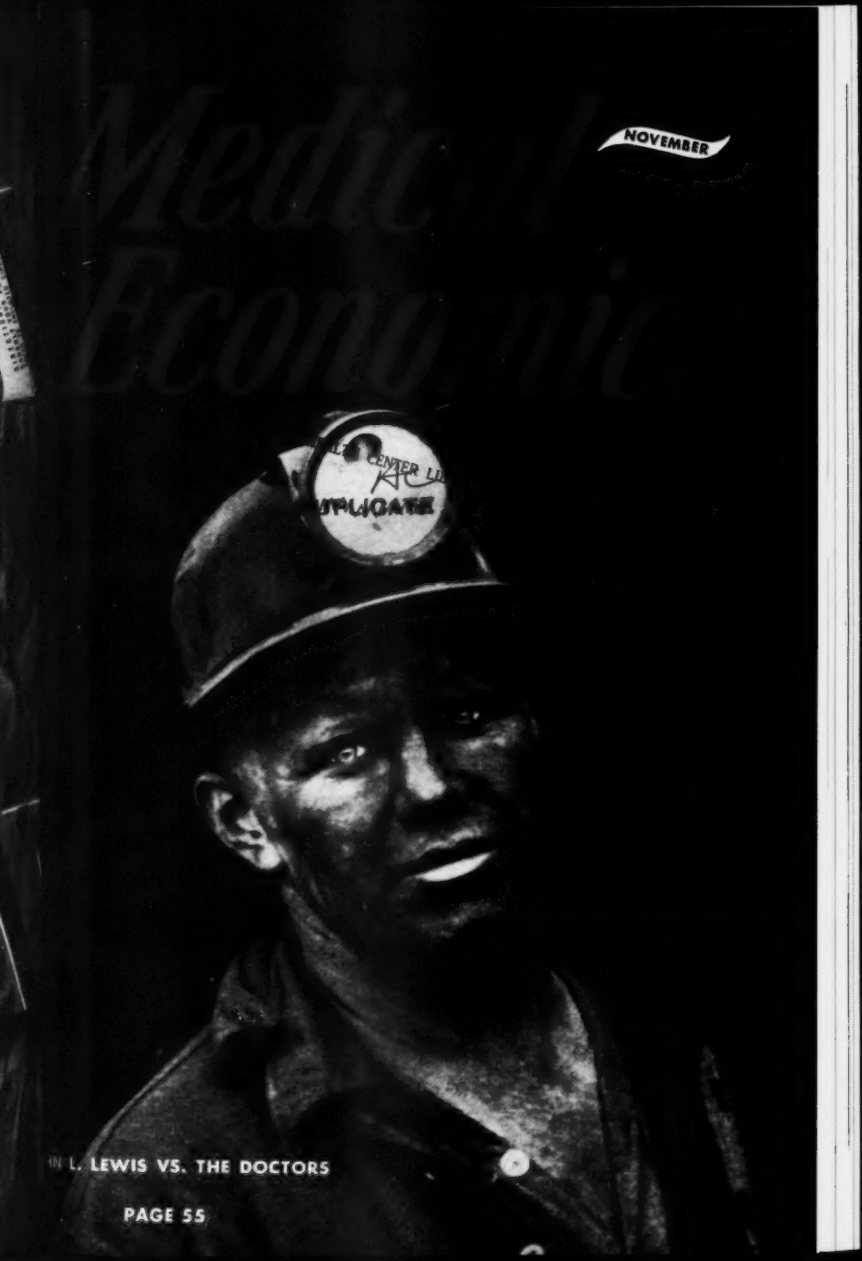
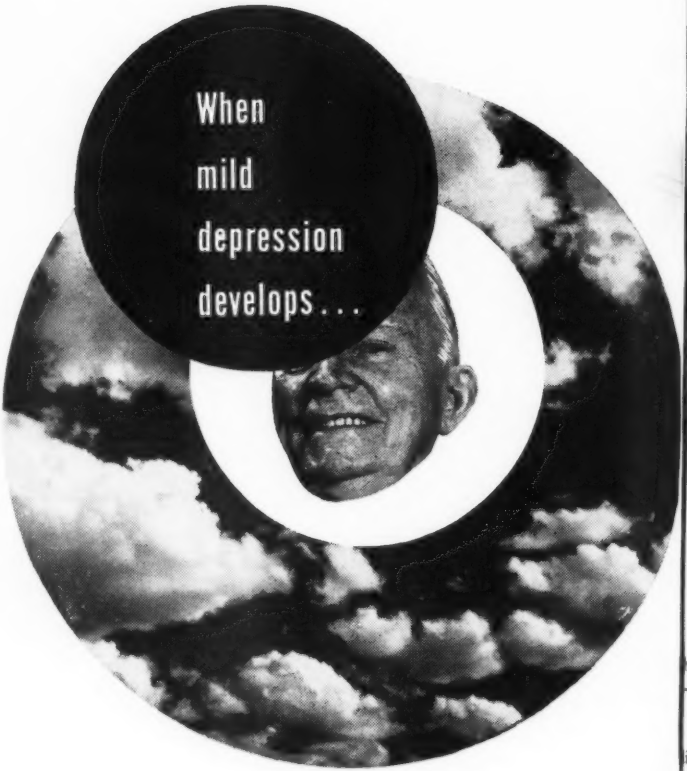




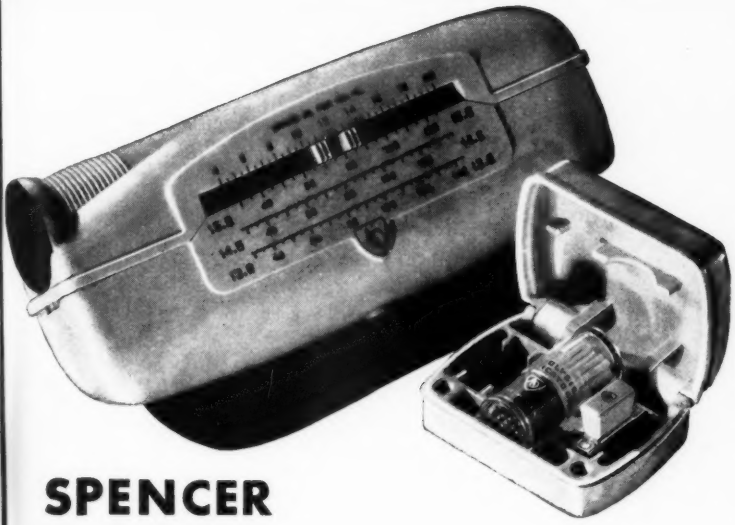
. . . during Convalescence . . . in Dysmenorrhea . . . following Childbirth . . . at the onset of the Menopause . . . following Bereavement or Misfortune . . . in Old Age . . .

. . . *Dexedrine* may be relied upon to increase the patient's accessibility to treatment; to effect a remarkable improvement in mood and outlook; and to aid in restoring a normal grip on life and living.

Dexedrine Sulfate tablets

(dextro-amphetamine sulfate)

Smith, Kline & French Laboratories, *Philadelphia*



SPENCER
Hb *Meter*

Brings Laboratory Accuracy to the Bedside

This new hemoglobinometer makes it possible for anyone to measure hemoglobin concentration as accurately as with the better laboratory methods —less than three minutes after blood has been extracted.

The Hb Meter is small enough to fit the pocket or bag, eliminates dilution liquids, volumetric measurements and tables, and operates *anywhere* from self-contained dry cells (or electric outlet). It is ideal for instant, on the spot use at the hospital, office or patient's bedside.

The process is simple. Blood is dropped directly onto a glass chamber and hemolyzed with a chemically impregnated applicator. Then the chamber is inserted, the illuminating switch pressed, and the lever moved until the fields match. Hb concentration is then read directly from one of the four scales either in grams per 100 ml or in percentages based on 15.6, 14.5 or 13.8 grams standard.

Price Hb Meter outfit, complete $34.50

THE WENDT-BRISTOL COMPANY

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Columbus, Ohio

DOCTOR . . .
PREPARE NOW FOR WIDER ACTIVITIES

The task of the physician today is greater than ever before. To help him in administering his many duties, it is essential that he use new, modern, efficient equipment.

Modernize your offices and equip them with time-saving and effective apparatus.

Doctors whose practice includes Obstetrics, Internal Medicine, Dermatology, Pediatrics or Orthopedics, will find frequent use for ultra-violet radiations.

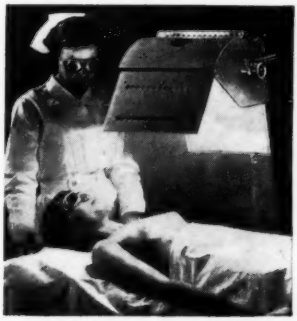
We recommend the new Hanovia Luxor Alpine Lamp which has a wide range of clinical usefulness.

Complete information will be furnished upon request.

We recommend the New

HANOVIA LUXOR ALPINE LAMP

which has a wide range of clinical usefulness



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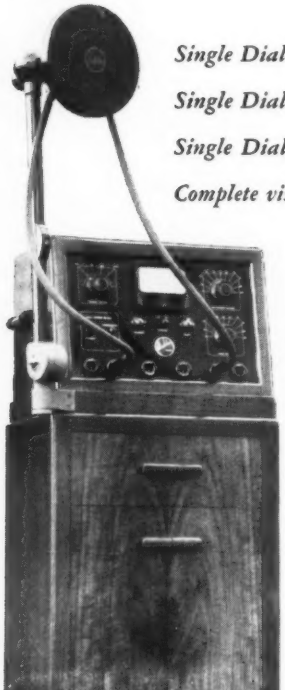
Simplicity

The Birtcher-Built Challenger Short Wave Diathermy is designed for utmost simplicity of operation and control.



Single Dial control of pad applications.

Single Dial control of induction cable applications.

Single Dial control of induction drum applications.

Complete visibility of pilot light from all angles.

Power flows smoothly, steplessly up to 560 watts capacity, ample for all applications, providing deep heat and inducing hyperpyrexia when desired... yet NO EXCEPTIONAL ABILITY is required for operating these units.

Write for new Birtcher brochure, "Seven Basic Facts About Diathermy," mailed free on request. Dept. R

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Columbus, Ohio

Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

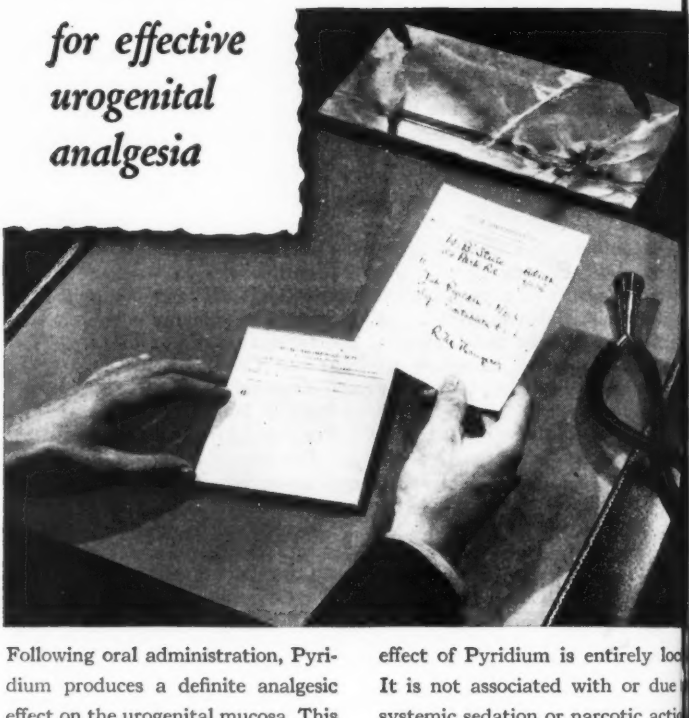
NOVEMBER 1946

Cover Photograph by Ewing Galloway

CIRCULATION 135,000

H. Sheridan Baketel, A.M., M.D., Editor-in-Chief. William Alan Richardson, Editor. Edmund R. Beckwith, Jr. and R. Cragin Lewis, Associate Editors. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager. 25c a copy: $2 a year (Canada and Foreign, $2.50 a year).

for effective urogenital analgesia



Following oral administration, Pyridium produces a definite analgesic effect on the urogenital mucosa. This action contributes to the prompt and effective relief that is so gratifying to patients suffering with distressing urinary symptoms.

Acting directly on the mucosa of the urogenital tract, this important effect of Pyridium is entirely loc
It is not associated with or due
systemic sedation or narcotic acti

Therapeutic doses of Pyridium m
be administered with virtually co
plete safety throughout the course
cystitis, pyelonephritis, prostatiti
and urethritis.

Literature on Request

REG. U.S. **PYRIDIUM** PAT. OFF.

(Phenylazo-alpha-alpha-diamino-pyridine mono-hydrochloride)

MERCK & CO., Inc. RAHWAY, N. J.

Manufacturing Chemists

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PYRIDIUM is the United States Registered Trade-Mark of the product manufactured by the Pyridium Corporation. Merck & Co., Inc., Sole Distributors.

B-D VACUTAINER
for BLOOD SAMPLING

Quick, Economical,

Versatile . . .

After blood collection — drops may be easily obtained for determining RH factor, red and white blood cell counts — with venous blood, and any other hematology tests where only a drop of blood is required.

The sealed unit — eliminates outside contamination and prevents possible spillage.

Procedure:
After tube is filled with blood, press tube firmly down on holder as illustrated. After each drop, release pressure and repeat for successive drops.

The same blood specimens may be split for Serology and Blood Chemistry tests — under sealed conditions.

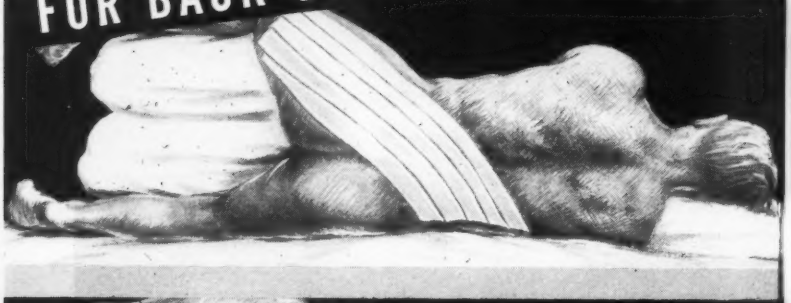
Procedure:
With needle attached to filled Vacutainer, penetrate stopper of tube containing anti-coagulant, as illustrated.

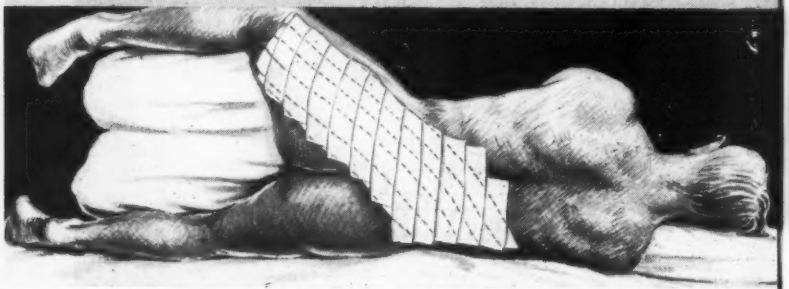
B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

Splinting the lower back and posterior muscles

FOR BACK STRAIN WITH SCIATIC





(Illustration from "Therapeutic Uses of Adhesive Plaster" published by Johnson & John

• The technique illustrated utilizes three layers of "ZO"* Adhesive Tape. The first layer of long strips of 2" tape begins about three inches above the knee and ends on the opposite side of the back, at the level of the twelfth thoracic vertebra. The second layer (lower illustration) consists of short crossing strips. The third layer (not shown) is applied like the first layer.

RED CROSS*
"ZO"
ADHESIVE TAP

ORDER FROM YOUR DEAL

Johnson & Johnso

*Trademark of Johnson & Joh

Panorama

► So smooth is the parliamentary procedure at AMA sessions that the American Bar Association has sent scouts to see how it is done . . . Another No. 1 for California is the Medical Veterans News, a handsome, 24-page monthly published by the Medical Veterans Association of Los Angeles . . . Protestant Episcopal National Council bought four fully equipped "package hospitals" from Government surplus and shipped them to China, Liberia, and the Philippines . . . What goes up: U.S. population will rise to peak of 165 million in 1995, then decline gradually, the Census Bureau predicts . . . Radioactive materials, widely hailed as latest "medical miracles," have been deflated somewhat by physicists who told UN commission on atomic energy that such materials have limited therapeutic value now and that much research remains to be done on them.

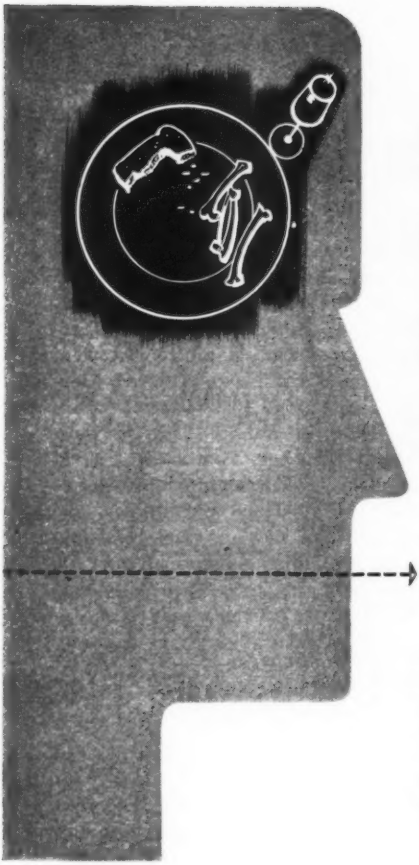
► Apprehensive parents are inquiring about a new poliomyelitis insurance policy which offers up to $5,000 in benefits at a $3 annual premium . . . Sign of the times: Illinois State Medical Society, having engaged a public relations counsel, plans to work more actively against compulsion . . . Dr. Wallace H. Graham, personal physician of President Truman is now a brigadier general; his dad, James W., long-time friend of the President's, is better known as a perennial battler against the closed-hospital system . . . Mouthwash manufacturers and subway riders are pondering news that garlic-and-onions oils, 2,500 times as potent as the bulbs themselves, have been developed.

► George Gallup says wives manage the funds in 32 per cent of U.S. homes, husbands in 29 per cent, both in 39 per cent, but offers no statistics on who manages the husbands . . . San Francisco Medical Society says it was much cheered by selection of Dr. George Lull as field general and "other signs of rejuvenation in the AMA" . . . American Hospital Association is pushing hard to establish routine chest X-raying of all patients and employes in general hospitals, as a means of checking tuberculosis early . . . Life insurance rates are from 10 to 15 per cent

higher now than in 1942; fire rates are down, but need for increased coverage brought about by realty inflation makes policy costs generally higher . . . New V.A. hospitals have oxygen piped into rooms from a central supply . . . Uncle Sam paid tipsters $55,000 last year for information on tax dodgers; most were former employes who turned in ex-bosses.

▶ With money tightening up a little, medical societies are again suggesting that doctors use credit bureaus to determine patients' financial status and paying habits . . . Washington U. School of Medicine has added a department of medical illustration . . . Claiming that California's new disability insurance program was weakened by legislative "sabotage," the state CIO advises workers to go to private insurance companies for "better protection" . . . Illinois Medical Journal will pay off, to the extent of $300 annually in prizes, for the best scientific papers received and published . . . Navy is forced to slacken discharge of medical corpsmen because of overload of war casualties in Navy hospitals . . . One world, many branches: Now it's the World Organization of the Teaching Profession, set up by delegates from thirty nations . . . Aside to Bob Hope and Miriam: The average person brushes his teeth in 67 seconds, when he should take a full three minutes, according to an American Dental Association survey made with mirrors . . . Drs. Francis A. Snidow of El Paso and Richard D. Pettit of Pasadena have been appointed consultants in obstetrics and gynecology to the Secretary of War.

▶ Self-constituted "authorities," currently dabbling in alcoholism, are chided by Dr. Anton J. Carlson, famed physiologist and president of the Research Council on Problems of Alcohol. He says nothing is known now about alcoholism except that some people like liquor better than others. He wants distillers to kick in some money to finance research . . . Trying hard, anyway: Congress has appropriated more than $10 billion for veterans in the current fiscal year (three-quarters of it to the V.A.) and since 1940 has enacted 196 laws affecting them and their dependents . . . Honorably discharged service dogs are entitled to free veterinary care, says the V.A., if their ailments are service-connected . . . American Dental Association has distributed more than 750,000 copies of a pamphlet explaining its opposition to compulsory prepayment insurance, and has still more.



Here's Food for Thought

Many people find food for thought *after* they have finished their meals. For too often overindulgence in eating, drinking and smoking starts them seeking prompt relief from nausea and stomach upset.

When such distress is due to gastric hyperacidity, BiSoDoL the effective antacid alkalizer can be depended on for quick, pleasant relief.

May we suggest you try BiSoDoL in your practice?

BiSoDoL

POWDER • MINTS

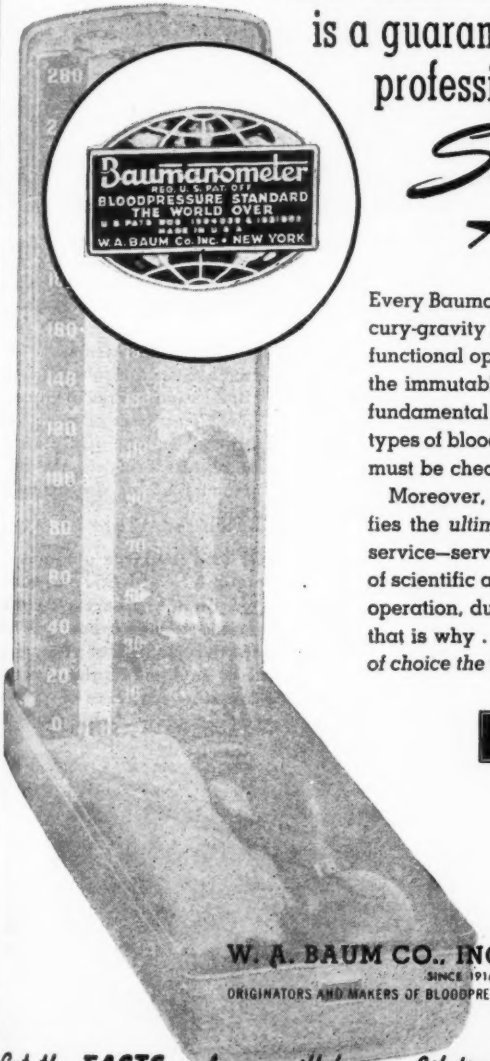
WHITEHALL PHARMACAL COMPANY

22 East 40th St., New York 16, N.Y.

Get

The name Baumanometer is a guarantee to the profession of

Scientific Accuracy



Every Baumanometer is a true mercury-gravity instrument . . . its very functional operation is based upon the immutable law of gravity—the fundamental principle by which all types of bloodpressure instruments must be checked for accuracy.

Moreover, Baumanometer signifies the *ultimate* in bloodpressure service—service measured in terms of scientific accuracy, simplicity of operation, durability and beauty—that is why . . . *it is the instrument of choice the world over.*

Lifetime Baumanometer
STANDARD FOR BLOODPRESSURE

W. A. BAUM CO., INC., NEW YORK 1
SINCE 1916
ORIGINATORS AND MAKERS OF BLOODPRESSURE APPARATUS EXCLUSIVELY

Get the **FACTS** *and you will buy a Lifetime Baumanometer*

Because there is

*Margolis, H. M.: Diagnosis and Treatment of Arthritis and Allied Disorders, New York, N. Y., Paul B. Hoeber, Inc., 1941, p. 59.

Virtually all recently published reports dealing with the treatment of arthritis stress the therapeutic value of *all* the essential vitamins in the management of arthritic patients.

Vitamin D Many investigators have reported beneficial results from the use of massive dosage of vitamin D in the treatment of rheumatic disorders. In practically all of these reports, however, the need for adequate amounts of *all* the essential vitamins is stressed.

Vitamin A The need for large amounts of vitamin A by arthritic patients is based on the observation that arthritics require from 4 to 10 times the quantity of vitamin A usually ingested in the average diet, hence the frequent occurrence of vitamin A deficiency symptoms in arthritic patients.

Each Capsule Contains:

Vitamin D (Irradiated Ergosterol)	50,000 U.S.P. Units
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Ascorbic Acid	75 mg.
Thiamine Hydrochloride	3 mg.
Riboflavin	2 mg.
Pyridoxine Hydrochloride	0.3 mg.
Calcium Pantothenate	1 mg.
Niacinamide	15 mg.
Mixed Natural Tocopherols	3.4 mg.

(Equivalent in biological activity to 3 mg. of Alpha Tocopherol)

striking evidence of nutritional abnormalities...*

Vitamin B COMPLEX — *Thiamine, Riboflavin, Pyridoxine, Calcium Pantothenate.* That relatively large amounts of the B complex vitamins are required in the treatment of chronic arthritis has been reported by many rheumatologists. Characteristic B complex deficiency symptoms frequently encountered in arthritic patients not only unfavorably affect the course of the arthritic process, but also add to the discomfort typical of the syndrome.

Vitamin C — In patients with chronic arthritis the requirement of vitamin C is greatly increased. Abnormally low blood levels of vitamin C have been observed frequently in arthritic patients.

Vitamin E — Beneficial results have been obtained with vitamin E when fibrositis complicates the arthritic involvement. Since involvement of the soft tissue is almost the rule in arthritis, vitamin E finds a rightful place in the management of these patients. Vitamin E is known to be involved in the metabolism of skeletal muscle.

DARTHRONOL

Darthronol presents—in one capsule and in correlated indicated potencies—these nine vitamins which many investigators assert play an important role in the management of the arthritic patient.

Complete bibliography sent on request

J. B. ROERIG & COMPANY
536 Lake Shore Drive • Chicago 11, Illinois

DARTHRONOL *for the Arthritic*
a **ROERIG** *Preparation*

Speaking Frankly

Car-less

Within the last month or so, at least three persons in my immediate neighborhood have been able to get new cars. I, a physician-veteran, cannot obtain one although my name has been on the waiting list for more than six months. When I asked the lucky ones, "How come?" they laughed embarrassedly and said, "Oh, you know what you have to do these days to get anything that's scarce."

I surrendered three years of my life to practice medicine in the Army. Now I have to walk the streets or use taxis to practice in civil life. And the boys who stayed at home and made a good financial killing go to the black market for their "pleasure cars." To such a system—nuts!

M.D., New York

Taft

I have read with a great deal of interest Senator Taft's National Health Bill, S.2143. I feel that in general it will meet with the approval of the medical profession. It has practically none of the objectionable features of the Wagner-Murray-Dingell bill or of the Pepper maternal-and-child proposal. It appropriates money at the Federal level for the care of indigent sick at the state level.

The last Virginia legislature anticipated several of the provisions of the Taft bill. It appropriated funds for a survey of the state to determine where hospitals were most urgently needed. It also appropriated money for an examination of all school children. However, it did not make any provision for the correction of remediable defects in indigent children. I feel that Senator Taft's bill might help in this respect.

An interim legislative commission was appointed to study the health situation in Virginia—particularly care of the indigent sick—and to weigh the role of prepayment medical and hospital care. This commission is to report to the next Virginia legislature, in 1948. Passage of the Taft bill would be quite an incentive to the state legislature to take steps to cooperate with the Federal Government.

Julian L. Rawls, M.D., President
Medical Society of Virginia
Norfolk, Va.

Piracy

Sooner or later, in locker-room conversation, the talk gets around to patient-piracy. Yet I venture to say that if every alleged case were investigated, not one in ten would be traceable to a deliberate attempt on the part of one man to snare the patient of another. Appearances may be damaging; the facts, quite innocent.

When a patient switches doctors

It's prescribed be

Rhinitis . . .

Sinusitis . . .

Nasopharyngitis . . .

Pharyngitis . . .

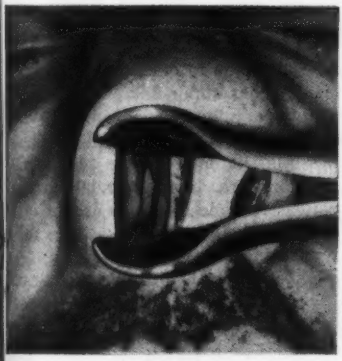
Paredrine-
Sulfathiazole
Suspension *Vasoconstriction in minutes*

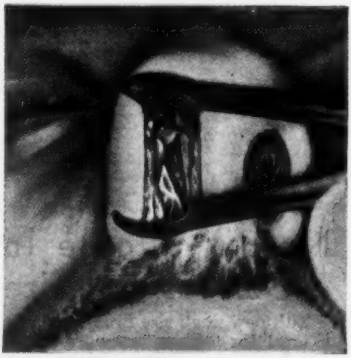
. . . Bacteriostasis for hours

(Left) I
Turbinat
passage
(Right)
Turbinat
rendered
middle t

Smith, V

...because *it* works...





(Left) **Before administration of Paredrine-Sulfathiazole Suspension:** Turbinates acutely inflamed, highly engorged, and in contact with septum. Air passage completely blocked.

(Right) **30 minutes after instillation of Paredrine-Sulfathiazole Suspension:** Turbinates constricted; ventilation and drainage promoted. Infected areas rendered accessible to the sulfathiazole, which is lightly frosting inferior and middle turbinates.

Smith, Kline & French Laboratories Philadelphia, Pa.

there is rarely any attempt by the physicians to discover, jointly, why a change has been made. The patient may have felt that he was not being helped or was being overcharged; perhaps he wanted to duck payment of a bill; perhaps, on a particular visit, he decided that he wasn't getting the doctor's undivided attention. In any event, knowing that he has free choice, the patient makes a change. If medical ethics are involved, he feels it is no concern of his.

He may or may not tell his new doctor about previous treatment. Yet deft questioning will usually reveal the facts. It will then be up to the doctor to contact the physician he has superseded. The courtesy of a phone call or letter will cement good relations and avert a possible rift between the two men. What's more, it may obviate a lot of wasted time and expense in going over the same ground, especially if the trouble is obscure.

Swan Ericson, M.D.
Le Sueur, Minn.

Practical

You advocate aid for the young doctor settling in a small town. The best aid he could get would be a concerted effort by M.D.'s in neighboring towns to refrain from making calls in his territory.

M.D., Ohio

Tripled

It's often difficult to decide what is concidence and what is plagiarism. But some cases leave no doubt. I refer to the tribute to the small-town doctor, made by Rod Hendrickson over the National Broadcasting System and quoted in September MEDICAL ECONOMICS. The

same tribute was expressed in the September Reader's Digest and credited to Damon Runyon.

Actually, the original was written by Dr. Wilmer Krusen in the American Magazine about fifteen years ago.

P. I. Nixon, M.D.
Austin, Tex.

Irregulars

In a recent issue of MEDICAL ECONOMICS "Disabled Officer" claims gross injustice in retirement awards by the bureaucratic hierarchy in the War Department. That this discrimination exists is proved by a reputable Washington publication. It states that not one in more than 1,000 Regular Army officers recommended for retirement has been denied disability compensation. But of 25,000 Reserve officers recommended for retirement disability, over 60 per cent have been denied disability pay.

M.D., California

Offices

From time to time you publish excellent plans for doctors' offices. Why not extend this service by inviting physicians who are about to build or renovate to send you their plans for possible publication and comment?

L. G. Steck, M.D.
Chehalis, Wash.

They're invited.

Intransigent

As an obstetrician, I invariably insist upon my full fee of $125 whether the patient is a charwoman or a society matron. I can't see that sliding scale business. If I were to accept a poor girl for $50, she'd certainly tell all her pals about it, and they in turn would say: "Why


The Why of
BRISTOL
12 TABLETS
NO. 187
Penicillin
Tablets (Oral)
EACH TABLET CONTAINS
25,000 Units Penicillin
Calcium Buffered with
Calcium Carbonate
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LABORATORIES INC.
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SYRACUSE 1, NEW YORK

penicillin tablets...

When an initial infection requiring repeated injections of penicillin has been controlled, blood levels of therapeutic efficacy may be maintained with PENICILLIN TABLETS ORAL. Such treatment is also useful after tonsillectomy and in tooth extraction.

The ratio of dosage of penicillin tablets to parenteral penicillin is approximately five to one, depending upon the type of infection.

BRISTOL PENICILLIN TABLETS ORAL

are supplied in two strengths—25,000 and 50,000 units. They are well-tolerated by both infants and adults.

Now available at your pharmacist or supply dealer in packages of twelve tablets each.

should I be delivered by my family doctor when I can get a specialist for $50?" I'd soon have an office full of such patients and my other practice would suffer.

On the other hand, I never increase my fee for a wealthy woman, even for the type who'd like to brag, "Oh, my confinement cost me $500."

M.D., Massachusetts

Addressee

When a doctor moves, he is followed by a stream of lower-than-first-class mail for which the postmaster requests forwarding postage. The physician pays to have it forwarded because he doesn't want to chance missing something important. The whole thing wastes time and money.

Before I moved recently, I had my new address printed in large, bold type on my old letterheads. I sent one to each of the pharmaceutical houses that had been sending me material. I also used this device to have my address corrected on magazine mailing lists.

Donald W. Leonard, M.D.
Cambridge, N.Y.

Defroster

"A Memo to My Boss" (September MEDICAL ECONOMICS) hit me in a tender spot, for I recognized many of my shortcomings and they looked bad in print! "A Reply to My Secretary" was pretty weak—as my own would be if I were to try to make one. But to any medical assistant I'd make one suggestion: "*Please* don't sulk! If anything I do distresses you, wait until the strain is off and talk it over with me. Don't give me the utterly-polite-but-distinctly-chilly treatment. I get

IT's something to rue... if patients don't chew!

Don't let your patients fall into the easy habit of "skipping" foods that give teeth and gums their needed daily exercise!

Eating Nabisco Shredded Wheat—at least once a day—is the easiest way to get patients to do their *functional chewing.* For Nabisco Shredded Wheat is so crunchy-delicious, so full of the good *natural* whole-wheat flavor, patients really love it . . . young and old!

And it's just as good for them as a bowl of hot cereal, without the bother!

For fun, flavor, and *functional chewing,* get your patients eating Nabisco Shredded Wheat, the original Niagara Falls product, every day.

it from my wife regularly and I hate it. I can divorce *her* (and I probably will) but I'd hate to lose *you*."

M.D., Montana

Cobwebs

You say that "To shift his practice to another state, a senior surgeon often finds himself sitting with medical students to be grilled in the chemistry of hippuric acid or in infant feeding." Quite true! And it's doubly embarrassing when the oldster knows that the students are going to acquit themselves much more admirably than he.

M.D., Missouri

Bottler

In "New Tricks for Old Bags" (September MEDICAL ECONOMICS) I fail to find any provision for either urine collection or for on-the-spot urinalysis. In my bag, a catheter, a few clean 2 oz. bottles, and material for tests are standard equipment.

Bernhard A. Fedde, M.D.
Brooklyn, N.Y.

Ridden

When I started to practice, I accepted the offer of a local fraternal society to become its doctor at a salary of $2,000 a year. I quit in three weeks! Not only did I get members but also the relatives of members. My waiting room was always jammed with people, and there was no way of telling who was a paying patient or who would get a complete examination and then tell me he was the "cousin of a member" and therefore a free rider. Soon it became evident that I was practicing medicine for about 20 cents a call and depriving other doctors of their legitimate patients.

M.D., Massachusetts

Now We Are Producing for Your X-Ray Needs

Typical of today's accelerated production lines in our Chicago plant is this lot of x-ray units, in the final stages of assembly and inspection.

It's the well-known Model R-39, resuming its characteristic role as the shockproof, all-round diagnostic unit which, because it is so compactly designed, almost invariably solves the problem of limited floor space. That's why you so often see it in the offices of specialists, in private clinics, and in many hospitals.

Here's the power you need (100 ma and 85 kvp) for radiographic and fluoroscopic diagnosis; a double-focus genuine Coolidge tube which serves both over and under the table; unusual flexibility for positioning the patient horizontally, angularly, or vertically; and an operator's control so refined and yet so simple to operate that you can consistently produce radiographs of the preferred diagnostic quality.

Model R-39 may well prove ideally adaptable to your specific x-ray needs at this time. Why not write for full particulars today. Ask for Publication 2567. Address General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Ill.

GENERAL ELECTRIC X-RAY CORPORATION

to combat persistent depression in the aged patient

Old age sometimes brings a severe and lasting depression, marked by self-absorption, withdrawal from former interests and loss of capacity for pleasure. This depression often aggravates underlying pathology by interfering with exercise, appetite and sleep.

Because of its power to restore mental alertness and zest for living, Benzedrine Sulfate helps to overcome depression and anhedonia in the aged. Obviously, careful observation of the aged patient is desirable; and the physician will distinguish between the casual case of low spirits and a true and prolonged mental depression. The dosage should be adjusted to the individual case.

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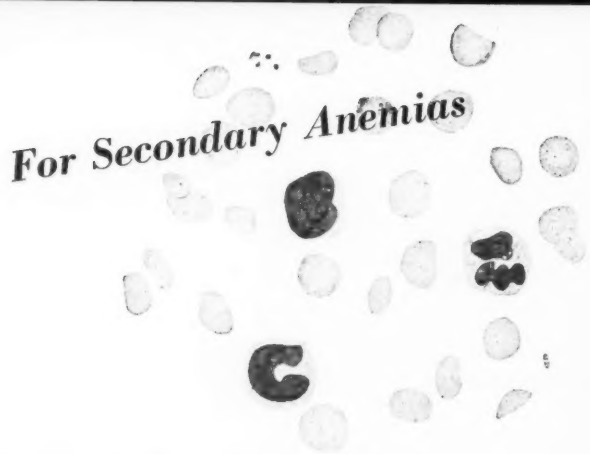


Campobiol is a therapeutically effective, potent, well tolerated combination of vitamin B complex factors with liver concentrate and iron. Marketed in easy-to-swallow gelatin capsules, with a pleasing aromatic odor.

EACH CAPSULE CONTAINS

Thiamine hydrochloride (vitamin B_1)	2 mg.
Riboflavin (vitamin B_2)	2 mg.
Nicotinamide	10 mg.
Ferrous sulfate (anhydrous)	100 mg.
Liver concentrate (1 to 20)	200 mg.

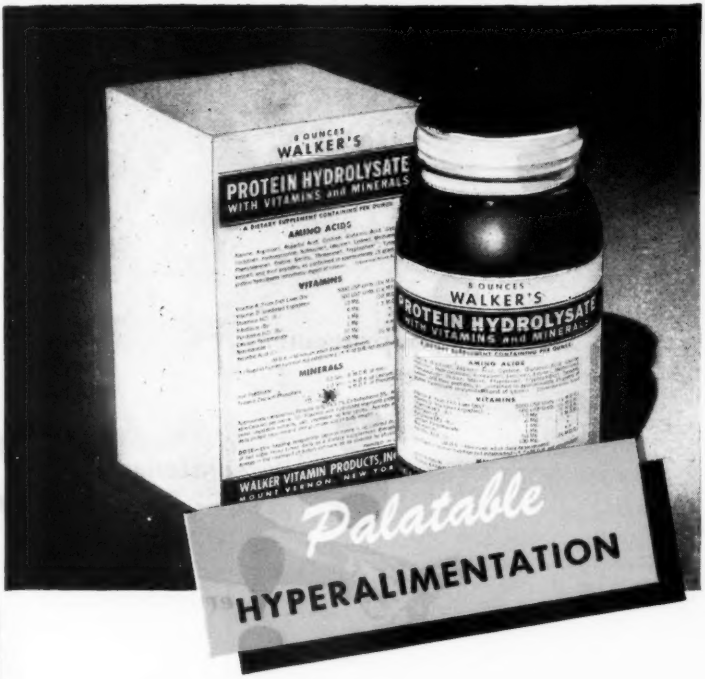
Prophylactic dose for adults: 1 capsule daily. Therapeutic dose for adults: 2 or 3 capsules three or more times daily, depending on severity of the anemia.

Campobiol
TRADE MARK

Brand of
Vitamin B COMPLEX Factors
with LIVER Concentrate and IRON

SUPPLIED IN BOTTLES OF 50 AND 200 CAPSULES

WINTHROP CHEMICAL COMPANY, INC.
Pharmaceuticals of merit for the physician • New York 13, N. Y. • Windsor, Ont.



There's growing emphasis on hyperalimentation as an adjunct to therapy. WALKER'S PROTEIN HYDROLYSATE WITH VITAMINS AND MINERALS has the pleasant savor of fine bouillon assuring patient acceptance when prescribed in: Pre- and postoperative dietary therapy, peptic ulcer and certain other gastrointestinal diseases, nutritional edema and anemia, pregnancy and lactation, febrile disease, periods of active growth and aging, and wherever protein hydrolysate-vitamin supplementation is indicated. Available through prescription pharmacies. Professional literature on request.

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with VITAMINS *and* MINERALS

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In the troublesome and commonly encountered eczematous eruptions and particularly in those involving a seborrheic factor, Pragmatar will often bring dramatic improvement.

Perhaps the most convincing evidence of the unusual effectiveness of this outstanding tar-sulfur-salicylic acid ointment is its widespread acceptance by dermatologists, and the impressive success with which it met the exacting demands of wartime military use in every climate and under every adverse condition.

Pragmatar (with sulfur and salicylic acid)

highly effective in an unusually wide range of common skin disorders

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Local measures play an important role in the therapy of such rheumatic affections as arthritis, arthralgia, myositis, and bursitis. Through active hyperemia, reparative processes are hastened and disposal of metabolites is encouraged. Thus pain is relieved, and a sensation of local warmth adds further to the patient's comfort. Baume Bengué, through the influence of its menthol and methyl salicylate, provides the type of local therapy needed in rheumatoid affections. An appreciable amount of its salicylate is absorbed percutaneously, augmenting the influence of systemic measures.

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Sidelights

Who's a lobbyist? Last month, that question was arousing considerable concern within the medical profession as well as in Washington circles.

Congress, in its reorganization act, had ruled that lobbyists must register with the Clerk of the House and with the Secretary of the Senate. Lobbyists must report who pays them, and how much. They must list the legislation they seek to influence.

But there is a joker in the law: Persons whose lobbying is only "incidental" to other activities need not register. And "incidental" is not defined in the act.

Thus it would appear certain that paid officials of such organizations as the National Physicians Committee and the Association of American Physicians and Surgeons would be required to register, for it could be demonstrated that their principal concern is the combating of pernicious legislation. But what of the public relations officer of a state medical society? He might say with justice that his attempts to influence national legislation, by one method or another, were merely incidental to his main job of promoting good will among the public for the medical profession. And a hostile Congressman might complain to the Department of Justice (which is charged with enforcing the law) that promoting public esteem is just another way of fighting legislation. Whatever the final legal judgment, the left-wing penpushers would be assured a journalistic field day.

The New York Sun, which presumably keeps its finger on the public pulse, has paid due heed to the appointment of Dr. Frank G. Dickinson as economist of the revivified AMA Bureau of Medical Economics. Its AP dispatch noted that Dr. Dickinson had been associate professor of economics at the University of Illinois, an instructor at Pennsylvania State College, and an insurance consultant. But the Sun, with a nice regard for placing first things first, published the item on its sporting page, with the head, "Football Rating Ace is Medical Economist." Far more newsworthy, for Sun readers at least, was the fact that Dr. Dickinson, back in 1924, had invented a mathematical formula for rating college football teams.

Any writer who argues for the status quo argues a dull case. So it's not surprising to find that most articles about health insurance in popular magazines tend to favor the cause of Federal medicine. Albert Q. Maisel is no exception. His piece entitled "Battle of the Bed-

side" in Collier's, Sept. 21, disguises but thinly his advocacy of a compulsory health insurance system.

Like many "compulsorators," he sometimes becomes enthusiastic over arguments for "the cause" that have long since been exploded. He tells his readers, for example, that the "free choice of doctors" offered by "voluntary or medical society insurance outfits" is not free choice at all since it is limited to participating physicians. He neglects to explain that choice would be limited similarly under compulsory sickness insurance. Still more important is the fact, which Mr. Maisel's readers are not told, that while choice of physician is restricted somewhat in both voluntary and compulsory programs, the citizen today can, if he chooses reject voluntary coverage completely, while if compulsory coverage were provided he would have to accept it whether he liked it or not.

Mr. Maisel also makes the point that voluntary prepayment plans will be vulnerable in time of severe inflation. A Government plan, he says, would have an advantage in that deficits could be met simply by subsidies from the Federal treasury. Apparently he has yet to learn the basic economic law under which money out of the Government's pocket eventually means money out of the pocket of the taxpayer.

Mr. Maisel criticizes the Taft-Smith-Ball bill because it proposes a Federal health plan limited to persons who could not afford medical care. In our humble opinion, this piece of legislation makes sense. It seems to us to define the proper limit to which Government

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is deliciously flavored

TASTE IT YOURSELF!

Not just one, but two characteristics make this great new I. V. C. triumph outstanding to the Medical Profession:

1. DELICIOUS FLAVOR—send for a free sample—taste it yourself!
2. P. H. V. GRANULAR is the *first* Protein Hydrolysate with a complete chemical analysis of each essential Amino Acid.

This is the formula on the I. V. C. "P. H. V. GRANULAR" label:

Total Nitrogen 7%; Amino of Total Nitrogen 55%; Carbohydrates 46%; Moisture 4%; Ash 6%. Indicated average Amino Acid Pattern of Protein Hydrolysate content. (Calculated on 16% Nitrogen Basis).

*Arginine	3.6%	Cystine	1.3%
*Histidine	1.9%	*Methionine	1.9%
*Lysine	6.9%	*Threonine	4.0%
Tyrosine	4.2%	*Leucine	8.1%
*Tryptophane	1.0%	*Isoleucine	4.8%
*Phenylalanine	3.9%	*Valine	5.0%
		Glycine	4.1%

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SEND FOR SAMPLE —*Taste It Yourself!*

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aid should be extended.

Mr. Maisel goes on to say that "if the Government pays premiums for part of the people, it actually becomes 'the third party interfering in the relationship between doctor and patient.'" This point of view is likewise subject to challenge by anyone who has viewed the workings of the present medical system operated by the Veterans Administration. Here the physician-patient relationship is maintained in the usual manner. The doctor's compensation is on a fee-for-service basis. And he can accept veterans for treatment or not, as he sees fit.

Later in his article Mr. Maisel makes an observation about medical care for miners. Physicians, he says, are going to have to provide service for miners on John L. Lewis's own terms. Yet this is by no means certain. If the majority of physicians in mining districts affected by the Lewis agreement refuse to be dictated to by Mr. Lewis, insisting upon the provision of medical service on *their* terms, the United Mine Workers' head may find himself in the position of having to swallow some of his own medicine (see "John L. Lewis vs. the Doctors," this issue).

Mr. Maisel ends his article with a prediction: If Government insurance materializes, "Senators Wagner and Murray may find the medical chorus, which has so often denounced them as 'socializers' and 'regimenters,' singing a different tune." What's more, he adds, "this interested spectator has a private bet with himself that the chorus will still be led by Morris Fishbein. For no man in America has a better record for fighting rear-guard

You know why—arthritis. So does he. And he probably knows, as of course you do, that the etiology of arthritis is still an unsolved problem. Yet he comes to you for whatever relief you can give him.

We suggest a therapeutic trial of Sulphocol or Sulphocol Sol as a rational measure. Ever since the introduction of colloidal sulphur, clinicians have consistently reported favorable results, including the reduction of joint swelling and pain, as well as the prevention or minimization of further joint involvement.

Sulphocol Sol provides all the benefits of colloidal sulfur therapy, plus an important additional feature—the special protective colloid produces a marked nonspecific action which stimulates the general defensive mechanism of the body. Sulphocol is also available in capsules for oral use.

For additional data on Sulphocol therapy, write to the National Drug Co., Phila. 44, Pa.

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For oral use: Sulphocol, in bottles of 100 5 grain capsules.
For parenteral use: Sulphocol Sol, in 25 cc. vials, and in boxes of 12-2 cc. vials.

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PHARMACEUTICALS, BIOLOGICALS, BIOCHEMICALS FOR THE MEDICAL PROFESSION

actions to the next-to-last ditch, then joining his opponents, climbing on the band wagon, and, miraculously, turning up in the driver's seat."

On this last point, no comment.

Postscript to last month's MEDICAL ECONOMICS editorial on income surveys:

Proponents of Federal medicine, who would like to sell their philosophy, have sought to deprecate the level of M.D. earnings under private practice. Income studies made in recent years, indicating a steady upswing in the doctor's financial status, have interfered with this effort. As a consequence, many "W-M-D-ites" can be heard quoting doctor-income figures from surveys more than a decade old, made by such agencies as the Committee on the Costs of Medical Care.

A resident of doctorless Post Falls, Idaho, has written us in the hope of enticing some young M.D. to move into the community. Take our word for it that on at least one count it's far ahead of any other township in the country. "We have a good new high school," our correspondent writes, "a Catholic Church, three Protestant Churches, and a Dog Church."

Post Falls' spaniel sect, it seems, even goes so far as to offer its canine followers a year-round medical health plan. This news of dogdom's answer to Messrs. Wagner, Murray, and Dingell comes straight from the kennel. Our informant signs himself, "C. Schroeder, Bishop of Dog Church."

[*Continued on page* 116]

A WISE SELECTION

PERTUSSIN

as a rational therapy for coughs in

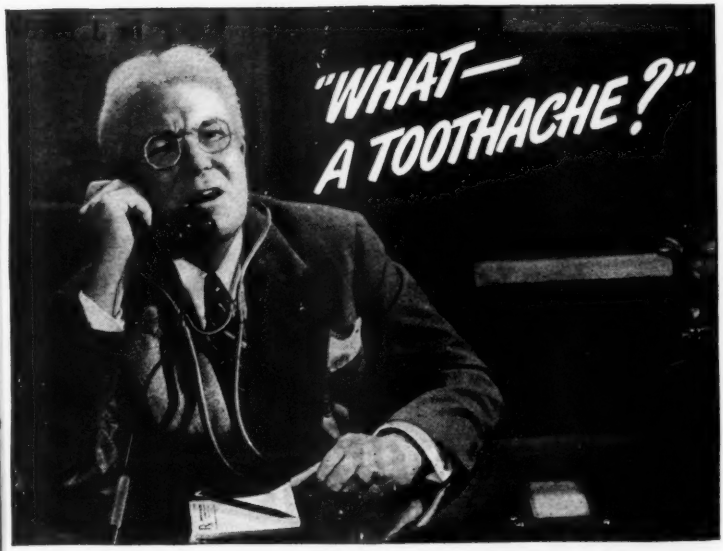
1. **Acute and Chronic Bronchitis**
2. **Paroxysms of Bronchial Asthma**
3. **Dry Catarrhal Coughs**
4. **Whooping Cough** 5. **Smoker's Cough**

The single therapeutic element in Pertussin is an extract of thyme (Process Taeschner) which is quickly absorbed and carried to the secretomotor center. It is highly beneficial in easing cough paroxysms not due to organic disease, because:

1. It stimulates secretion of the tracheobronchial glands to relieve dryness.
2. It facilitates the removal of mucus accumulation.
3. It improves ciliary activity.
4. It exerts a sedative effect on the irritated mucous membrane.

Pertussin is palatable, well tolerated, and free from any undesirable side action. It has been widely prescribed for over 30 years and deserves your recommendation for children, adults and the aged.

SEECK & KADE, INC. **NEW YORK 13, NEW YORK**



Doctor—has this ever happened to YOU?

Here's a suggestion, Doctor—treat emergency dental pain with the well-known POLORIS DENTAL POULTICE—provides prompt, safe relief until more complete dental treatment is available—usually eases pain without need for opiates or sedatives—will not interfere with subsequent dental treatment. For over 30 years the dental profession has prescribed POLORIS for pain caused by: Dental abscess • Pain after extraction • Erupting third molar • Irritation after filling • Other painful conditions of the teeth and gums, not due to cavity.

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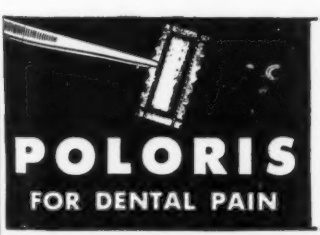
POLORIS is a scientifically tested and proven dental aid . . . acts on medically accepted principle of counter-irritation. Its active ingredients include capsicum and benzocaine in poultice form. Never advertised to the public—obtainable at all drug stores.



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Please send Free POLORIS samples to:

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IN THE TORTURE OF PERIANAL ITCHING

Relentless, unnerving, ano-perineal itching is among the most tormenting discomforts man is called upon to endure. The paroxysms of this frequently occurring syndrome appear without warning, day or night, and instantly rob the victim of further poise and productivity. Dependable, rapid relief is required to prevent serious emotional imbalance and traumatic lesions due to the irresistible desire to scratch. With Calmitol, such relief is promptly available. Calmitol quickly stops the annoying itching, and holds it in check for hours. Subsequent applications can readily be made at work, since the tube of Calmitol Ointment is easily carried in pocket or purse.

Calmitol stops itching by direct action upon cutaneous receptors and end-organs, minimizing transmission of offending sensory impulses. The ointment is bland and nonirritating, can safely be applied to any skin or mucous membrane surface. Active ingredients: camphorated chloral, menthol, and hyoscyamine oleate. Calmitol Liquid, prepared with an alcohol-chloroform-ether vehicle, should be used only on unbroken skin areas.

CALMITOL

THE DEPENDABLE ANTI-PRURITIC

Thos. Leeming & Co. Inc.

155 East 44th Street, New York City 17, N. Y.

Editorial

Balancing Act

Of the 45,000 ex-medical officers now back in civilian practice, many have a fresh slant on their work.

"My first assault landing gave me a new appreciation of the balanced life," says one ex-Army captain. "I felt thankful for the years of hard work behind me. But I desperately regretted missing all the things I hadn't done because I 'didn't have time.' "

A former surgeon for a Marine division speaks of the lasting impact made by the realization that "when a group of men are working together, each seems to accomplish more than when he works alone. And there's still time left for recreation."

Just the other day, a one-time major who served in the ETO said, "Before the war I used to work from eight in the morning to eleven at night. It didn't occur to me to do anything else. If the war hadn't come, I suppose I'd still be stomping the same old treadmill.

"I came home with a different viewpoint. Today I work hard, but I work fewer hours and, of necessity, more efficiently. My health seems better. I'm more cheerful. I don't have the nose-to-grindstone feeling that used to get me down.

"Working oneself into the ground may be all right for some men. But for me—no. Not only is life too short, but I think I can make a better contribution to the world by leading a balanced, well-rounded existence."

We know these three men well enough to attest their sincerity. They're no shirkers and never could be. They have simply learned to view themselves with new perspective.

They used to deplore the scant amount of time they had for their families. They neglected their health, shunned their friends, and shrugged off community activities—all because they were "too busy."

Of course, not all physicians think that their post-war lives *can* be rounded out. As one M.D.-veteran told us recently, "I found time-off a new and wonderful experience during my war service. But it's not consistent with medicine's fundamentals to try to achieve it in civilian practice. The only thing I'm on time for all day is my eight o'clock date for hospital rounds. My office hours start at ten. In the afternoon I make house calls. In the evening I handle patients whose jobs keep them from coming in during the day. And there are always emergencies. I stick to that routine seven days a week.

"I don't believe a doctor can try

to limit himself. He goes into medicine with his eyes open. I fully expect to have a coronary sometime in my fifties, although my family is a long-lived one. But a physician can't exist like other people and be honest to his profession."

There's no denying the gravity of a physician's moral obligation. But we're inclined to think that the men who attempt to balance their lives are facing their responsibility in a manner worth emulating. Suppose the doctor has that coronary and cuts ten years off his life. Even on the seven-day schedule and at twelve hours a day, he'll still owe his patients a couple of years. And that doesn't take into account the better care he could give with more rest, the role he could take in his community, or his defaulted debt to his family.

To some degree, a doctor's life will always be at the mercy of emergencies. But we believe it's possible for a physician to force his routine into a daily schedule that gives him time to pursue at least a semblance of the balanced life. We've seen it done. And we've seen the incalculable benefits that such an effort brings.

—H. SHERIDAN BAKETEL, M.D.

"AFTER ALL, DOCTOR—WHO'S TO DECIDE WHAT'S NORMAL AND WHAT ISN'T?"

Three Ways to Build Enrollment in Voluntary Prepay Plans

Ex-AMCP president outlines scheme to promote medical plans

How to spur enrollment, the jackpot question for physicians affiliated with over fifty health insurance plans sponsored by the medical profession, last month got an expert's $64 answer. With a sharp warning that "it's a race between education and catastrophe," Dr. Frank L. Feierabend, until recently President of Associated Medical Care Plans, Inc., outlined a three-point plan.

¶ Indoctrinate physicians with the merits of their local sickness insurance plan through a series of regional meetings; break down the "rugged individualism" which keeps some M.D.'s from participating.

¶ Utilize every possible medium for informing the public, including greatly expanded newspaper, magazine, and radio advertising.

¶ Employ more competent sales personnel; "there's a big selling job to do, and medical service plans can't be expected to sell themselves."

What results can such a drive produce? "In Kansas City last year," Dr. Feierabend told MEDICAL ECONOMICS, "we had 35,000 people enrolled in our medical service plan. Now we have about 100,000. I think we can show the same rate of growth on a national scale if the plans follow the outline I've suggested. That would mean about 15 million people enrolled in society-sponsored medical care plans by the fall of 1947. I believe that those figures would convince the public that the job can be done without Federal medicine."

But promotion of voluntary plans must be greatly intensified if that goal is to be reached, Dr. Feierabend emphasizes. Further, the educating must begin within the profession. "A great many doctors around the country say they don't want to have anything to do with these plans," comments AMCP's first president. "Those men must be reached by an educational program. Some physicians feel that the information they have acquired by studying medicine is theirs to do with as they please. That's not true, fundamentally. Their medical information belongs rightfully to the people.

"There's an incontestable national demand for low-cost sickness insurance embodying the free-choice principle. Physicians have to meet this demand, rather than cry to high heaven when social planners come along and offer something that the doctors have neglected."

Dr. Feierabend terms sentiment against the use of paid advertising for prepay promotion "nineteenth century stuff." No question of ethics is involved, he explains, since such advertising does nothing to enhance the practice of any individual physician. "It's a direct means of informing the public about medical service plans which must be tremendously expanded. Although it seems to work out best when handled locally, AMCP is now looking into the possibilities of doing some advertising on a national scale. Professional advertising firms and public relations concerns can be used in many cases."

The actual in-person selling doesn't require men with substantial sales experience, Dr. Feierabend believes. "In fact," he says, "I'd prefer that they hadn't done any previous selling at all. Medical service plans call for salesmen of a high type—men who get the feeling that they are doing something for humanity in the course of their work. I have found that a good liberal arts graduate makes the best salesman. Society-sponsored plans should pick sales personnel of broad background, nice appearance, and attractive personality rather than concentrating on men with long selling records."

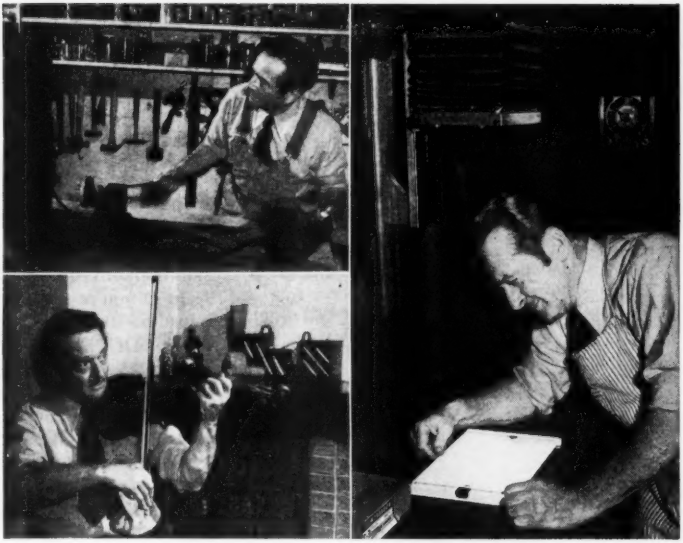
A great deal more remains to be done in enrolling national industrial groups, Dr. Feierabend believes, and it's something with which AMCP can help local plans. "Our own Surgical Care (Kansas City) hopes to enroll Trans World Airlines which currently has 15,000 employees all over the country and may soon have twice that number. The state in which the headquarters of a nation-wide firm is located should tackle that concern with national enrollment in mind."

Building enrollment is a job for each individual plan and for each affiliated physician, Dr. Feierabend emphasizes. AMCP can help with the coordination of local plans, and with technical organizational problems. "But," he says, "it will take the united efforts of individual physicians to boost enrollment in voluntary sickness insurance plans to the point where they are safe from socialized medicine's recurrent menace." —C. G. BENSON

Collector's Item

Having had no visible results after a year of sending statements and letters to a patient, the doctor turned the account over to a collector. A few days later, an indignant woman came into our office and wanted to know why we had done "this terrible thing." I explained: "We sent statements every month, but you ignored all of them. We had to do something."

"I *didn't* ignore them," she retorted. "I kept *every one* of them in my dresser drawer!" —V. AVERITT



Protean

"I just can't sit idle and look at four walls," says Dr. Max Schmidhofer of Chicago, and he means just that. As a practicing surgeon, he's normally active. As a practicing artist, chemist, composer, craftsman, fencer, fisherman, inventor, pianist, photographer, professor, and violinist, he's busy as a queen bee in mating season.

To while away a few hours, Dr. Schmidhofer set up a chemical lab in his spacious basement where he developed a new athlete's foot remedy, now widely used. An elaborate craft shop came next, and soon he brought forth an ingenious silent burglar alarm which he's patented.

His students at the Chicago medical school used to photograph the expert anatomical drawings he sketched on the blackboard. Some still use those photos in their practices today. Dr. Schmidhofer is adept at photography, set a county fishing record which still stands, and held a North American fencing championship some years back. An after-hours musician of skill, he's written many compositions for his concert-pianist wife, Esther Payne.

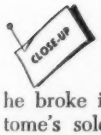
Piscator

If your favorite diversion happens to be trout fishing, you're not likely to find it just by stepping outside your office. Dr. Shirley L. Hadden, Chicago general practitioner, had to travel 180 miles each vacation-time to reach his favorite fly-casting nook in central Wisconsin. As he fished the quiet stream during one vacation season, the thought struck him: "What a spot for a private hospital!"

During the winter, he mulled over the possibilities of combining vocation with avocation. When summer rolled around, he was off on another trip—primarily to fish, but also to ask questions in the tiny village of Wild Rose. Could the community support a hospital? Wild Rose said yes—and made it stick with a gift of five acres of wooded land on Dr. Hadden's trout stream.

Today his striking, three-story, 24-bed hospital stands there, complete with operating room, laboratory, and X-ray department. Throughout the war, Dr. Hadden and his associates did yeoman work for the whole county. Now that the pressure has relaxed somewhat, he's finding more time to slip out the side door and down to the little trout stream that brought Wild Rose its hospital.

Pundit



He hasn't been to a football game since 1926, yet this summer he broke into Who's Who as that tome's sole gridiron authority. In the Manhattan phone book you'll find him as simply "L. H. Baker, football," but he's a practicing physician whose sideline has brought him enduring fame.

Dr. Baker turned to collecting football statistics for diversion, pure and simple. It wasn't long before news of his remarkable library —formally, the Baker Library of Football Information—got around. It's stacked now with 10,000 football programs from every college in the country, 200,000 photographs of gridiron stars, 5,000 volumes on every phase of the game.

Sports writers and fans alike constantly besiege him for elusive statistics. He recently assembled many of the answers in a book ("Football: Facts and Figures") hailed as tops among gridiron histories.

Dr. Baker shuns attending football games because crowds bother him, "and you know that leads to ulcers" (he's a gastro-enterologist). But he follows the games avidly by radio, indexing plays as he goes. Many a college coach would give his right halfback for Dr. Baker's catalogue of 4,000 diagrammed plays.

A Physician Reports on Russia

Boston surgeon finds Soviet practice equal to ours in three major categories

Russian medicine, as enigmatic as all Soviet post-war activity, this summer was exposed to the sharp scrutiny of a Yankee physician. Now back in Boston after a month's tour of the USSR, Dr. Edward L. Young has a story to tell. On at least three counts, he found Russian medicine the impressive equal of American practice.

A Hub City surgeon whose hobby is travel, Dr. Young jumped at an invitation to join a good-will delegation sponsored by Russian Relief, Inc. This group covered 5,000 miles within the country, visiting Moscow, Minsk, Leningrad, Stalingrad, and other large cities. Says Dr. Young, with some degree of amazement: "We found no restrictions of any kind. We took pictures freely, talked with anyone we chose. We were given a private plane by the Russian government, and went anywhere we felt like going.

"Every new American development is being studied eagerly by Russian scientists," Dr. Young reports. Emphasizing that he speaks only for what he saw and letting political overtones pass without comment, the Boston surgeon says that Soviet medicine impressed him particularly with its efficient child care program, its ability to organize, and its high-calibre surgery.

"Although one-third of Russia's population is now under the age of fourteen," Dr. Young explains, "the medical profession has taken on the job of supervising healthy as well as sick children. The Soviet program of preventive care is more extensive than ours and, to a considerable extent, it is being carried out just as it was planned. The task is complicated by several hundred thousand war orphans. No one knows just how many there are, but Minsk alone has 65,000. Nevertheless, the physicians are handling the job well.

"Every child in Russia is registered at birth and guided by the medical profession in his diet and exercise. I visited several orphanages and summer camps. Each

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▶ Dr. Edward L. Young, whose personal opinions of present-day Soviet medicine are presented in this MEDICAL ECONOMICS interview, is chief surgeon at Boston's Faulkner Hospital. A graduate of Harvard College and of Harvard Medical School, he has also taught surgery at the latter institution.

child seemed to receive excellent treatment in sickness. There are milk stations in the hospitals; but if possible, a mother comes to the hospital when there's a sick baby who needs nursing."

No major epidemics have hit Russia since the war's end, Dr. Young reports, terming this a medical achievement "unmatched in history" in view of the devastation which the country suffered. "It has been possible because doctors followed the mine detectors and the engineers into every ruined city," he comments. "Every civilian who returned to the city had to go through a physician's hands. Once back, he had to be inspected regularly. Every suspicious case was isolated.

"The medical profession was given complete control of sanitation, food, and water supply. Its job was not made easier by the retreating Germans' deliberate contamination of many drinking wells. I think that the absence of any major epidemic is a remarkable tribute to Russia's physicians."

Dr. Young adds further details to his glimpse of the profession's ability to organize successfully: "We have prided ourselves on our blood banks for a number of years," he observes, "but they are an old story to the Russians. Theirs have been in operation for 20 years. In 1930, the taking of blood from healthy cadavers was started in Moscow. After every sudden death the corpse is taken to a designated hospital. Their system is so well organized that the cadavers usually reach the hospital less than two and one-half hours after death."

Soviet surgery draws high praise from Dr. Young, who visited a dozen large hospitals in Moscow, Leningrad, and Minsk. "In Moscow, I spent a day with Dr. Sergei S. Yudin, one of the great surgeons of the world," he reports. "I watched eight or ten major operations. In the other hospitals—the largest contained 2,300 beds—I saw only the results, but they were enough to testify to the excellence of the surgery."

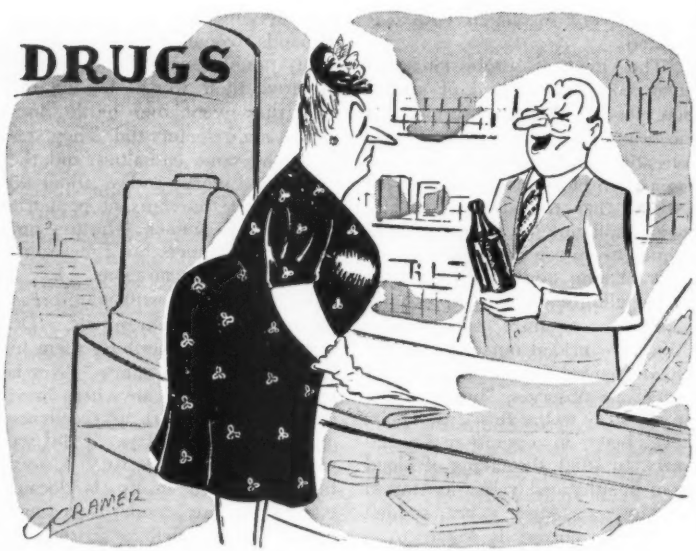
What about the role of Russia's distaff side? "Sixty-five per cent of all physicians in Russia today are women," Dr. Young declares. "It's by no means a war-inspired phenomenon. Because of the sex equality which the Soviet economy demands, women have had opportunity to enter medical schools and to prove their worth. During the war, they went into battle lines just as male doctors did. They suffered the same casualties, did the same good work. Today, about 95 per cent of the staffs of pediatric institutes are women. The top surgeons are still men, but I met some excellent women surgeons."

War damage is still widespread among Russian hospitals, Dr. Young reports, describing them as "physically in poor shape." "Nor is Russian medicine anywhere near its U.S. counterpart in excellence of equipment," he says. "I did see some fine gastro-intestinal X-rays; but on the whole, Russia doesn't come up to our standards in those fields. There's a definite shortage of penicillin. What they have they use well, and without the waste that we sometimes exhibit. Aside from penicillin, drugs in Russia seem to be used just as they are here."

Without going into pros and cons of the Russian physician's status as a civil servant, Dr. Young sketches briefly the Soviet medical system: "The Russian is entitled to complete medical care, and pays no fee when he goes to the physician of his district or to a hospital. But some Soviet doctors also have private practices on a fee-for-service basis.

"We visited one large collective farm which appeared to have complete medical coverage. Patients there go to the clinic of the district physician, or if seriously ill, are transferred to any required hospital. But occasionally, a patient prefers to go to Moscow to consult another physician. That is a private affair, and if he wants such care, he has to pay for it."

To care for more than 190 million people, Russia had 140,000 physicians in 1941, latest year for which figures are available. Under Health Minister G. E. Mitterev—a "discerning and personable man" with whom Dr. Young talked at some length—Russia is attempting to boost this total to a 1950 goal of 212,000. —R. C. LEWIS



"THIS WEIGHT-REDUCING MEDICINE IS DIFFERENT. IT'S TO BE SHAKEN AFTER YOU TAKE IT."

John L. Lewis vs. the Doctors

The issue: Shall physicians or miners control medical practice in twenty-six states?

For half a century the miners had known nothing but contract medicine, a system of prepayment under which independent doctors and hospitals furnish comprehensive care on a capitation basis. When they struck, earlier this year, they made it clear that they wanted a new deal in medicine. The Government took over, and the "Krug agreement" was signed. A month ago United Mine Workers was theoretically in control of the medical services being furnished to 400,000 miners in twenty-six states. Actually, the old contract system was still in effect and no one knew when it would be supplanted by a new one. The reason was simple: The UMW's head man, John L. Lewis, was saying nothing about his plans.

The Government still held control of all bituminous mines; the agreement signed by Secretary of the Interior Julius A. Krug would remain in effect only as long as the U.S. ran the mines. The owners were saying that they "couldn't afford" to take back the mines under the agreement, and John L. Lewis was telling them that they'd be lucky to get another offer that would be as good.

Several thousand doctors who had cared for the miners under the contract system formed the Association of Mine Physicians, whose objectives were: (1) to help the union work out a new plan of prepayment medical care; (2) to fight any attempt by Lewis to "take over" medical practice in the bituminous areas of West Virginia, Kentucky, Alabama, Pennsylvania, and Michigan. The physicians felt that the contract system was doomed, and most of them weren't sorry.

Present at the birth of the Association of Mine Physicians were representatives of the AMA, including Dr. Walter B. Martin, of Norfolk, Va., a member of the Council on Medical Service; Thomas W. Hendricks, executive secretary of that council; and Jay C. Ketchum, of Associated Medical Care Plans. The AMA knew full well that coming negotiations between the UMW and the mine physicians would be watched closely by the huge industrial unions of the country, which have been toying with the idea of running their own medical programs for some time, and by Social Security Administration stalwarts in Washington who are not too keen about the development of large-scale voluntary prepayment, especially when the doctors have a hand in

working it out.

Under the contract system, each miner paid about $2 a month to a general practitioner for comprehensive medical care for himself and his family in the home or office, and about $2 a month for specialist medical care and hospitalization in contract hospitals. There was no other comprehensive plan anywhere offering such a low rate.

But the miners wanted more than mere economy of operation. They wanted complete free choice of doctor or hospital, which they lacked under the contract system. They wanted bigger and better hospitals, more specialists, more doctors generally. Most important, they seemed to want to run the whole show.

On paper, at least, they *had* won control, for the Krug agreement had two important provisions:

1. It granted the miners a royalty of 5 cents a ton on all bituminous coal mined. It provided that the royalties (which amount to about $35 million a year) should go into a special health-and-welfare fund to be controlled by three trustees, one appointed by the union, one by the Government, and a third selected by the first two. By last month, no trustees as yet had been appointed, although royalties were piling up.

2. It created a medical and hospital fund to be placed under complete control of the union. Principal effect of this provision was to end the joint union-management control of contract prepayment and to give the UMW authority to set up an entirely new system.

The wording of the Krug agreement made it appear that the UMW was determined to control medical practice in the bituminous areas. The doctors were equally determined that it would not. They were prepared to cooperate fully, but not to abdicate. They told the union, in effect:

"We do not like the contract system any better than you do. We realize that it was forced upon us and upon you by economic circumstances. We'll work with you to try to find a better system. But we will not be dictated to."

What is this contract practice that has suddenly become a national issue? Physicians outside the mining areas have long regarded it as something subgrade, a little beyond the pale. Even in the bituminous areas there have been strenuous efforts to have the system abolished; but no adequate substitute has yet been found. Actually, contract practice is one of the oldest forms of prepayment in the country, a system that has not been modified in principle for half a century. Contract physicians are *not* company doctors; they are private practitioners who work on panels. Each one contracts jointly with a company and a union local to furnish home and office care for practically all conditions* and for all members of the local at the monthly fee of $2 a family. The company agrees to check-off (deduct) the $2 from the miner's paycheck and to remit it to the doctor periodically. The other check-off

*Among the few exclusions are venereal disease, infectious or contagious diseases, insanity, and alcoholism. Industrial accident cases are compensable under the workmen's compensation laws. Normal deliveries require an additional fee of about $20.

of $2 goes to a contract hospital for hospitalization and specialist medical care. The G.P. does only home and office work. When a patient is hospitalized, he relinquishes the case. Specialists are reimbursed by the hospitals.

Thus, the individual miner pays for a compulsory prepayment program which provides him no free choice of either doctor or hospital; he must accept the man and the institution his union chooses. Even the local does not have complete free choice; for while the mining company cannot force the local to accept any particular doctor or hospital, it can refuse to check-off for any man or institution it does not like. The only virtue of this type of "closed shop," say many doctors, is that it tends to keep subgrade physicians, osteopaths, chiropractors, and quacks out of mine practice.

Whether it is good or bad in principle, contract practice has been, up to the present, the only practical method of providing medical care for miners. Such care has not always been of the highest caliber, although it has compared favorably with that furnished a number of other industrial segments of the population. Without the check-off, most miners in recent years would have had practically no medical care at all, for they simply would not have paid for it.

Miners have long lived in an economic system that does not include the usual American qualities of thrift, self-dependence, and foresight. Vast numbers of them are almost childishly incompetent when it comes to handling money, having not yet advanced far beyond the virtual "peonage system" established by their European predecessors. Although the union eventually abolished the peonage system, a vast number of miners still live in an economic hang-over. They buy the necessities of life, and some of the luxuries, from company stores. They pay reasonable, competitive prices. But no money changes hands; everything is deducted from the paycheck.

It is not surprising, then, that a great many miners have come to consider the cash balance as "spending money," something that is meant to buy relaxation and not to pay debts. Much of it goes for

Focus of Infection

The woman's anxious voice came over the phone: "Doctor, can you come out to 211 East 9th to see Jim Johnson?"

"I imagine so. What's his complaint?"

"He's complainin' he's sick."

"I know. But is he sick in the head, sick in the stomach, or just where is he sick?"

"Oh," came the reply, "he's sick in the little room on the third floor in the front."

—S. H. BURNETT, M.D.

week-end drinking bouts, relatively little is put aside for the future. Under such conditions, the doctor must collect from the check-off or not collect at all. Private, fee-for-service practice exists in the bituminous areas, but not for miners.

The hospital situation is spotty. Within twenty miles of each other, there may be one top-grade institution and one that hardly deserves to be called a hospital. This reporter visited a modern, private institution of 100 beds in a town of 9,000 population. It is staffed with men in practically every specialty and has been approved by the AMA and by the American College of Surgeons. It offers facilities not often found in communities many times its size. Yet not an hour's journey away, there is another hospital—a ten-bed, one-doctor affair—located over a grocery store. Each collects the same contract rate.

This unevenness of service among the hospitals (most of them privately owned) has drawn the fire of the UMW. It plans to use some of its health and welfare fund to build new institutions. But until recently union locals insisted on complete control of such hospitals, with no public or professional representation on the boards of trustees. Doctors, granting the need for more and better hospitals, have refused to staff institutions under such unilateral control.

Are the UMW's demands for a new deal reasonable? Among contract physicians there is some difference of opinion. A few feel that the present system is adequate and should be continued. But most believe that medical service could be improved greatly. They point out that relatively few contract practitioners are young, vigorous, and possessed of recent training; while a great many have been in practice forty or fifty years. Under normal circumstances, the bulk of the work would, by this time, have been shifted to the shoulders of the younger men.

Before the war, the contract system did attract a large number of young physicians. They knew that by dint of hard work they could amass in four or five years enough money to establish themselves firmly in more typical American communities. War shortages changed all that. Today, the mining areas are grievously short of enough doctors to make even the present system work satisfactorily. In addition, a number of established men, impatient with the high-handedness of some union locals after the signing of the Krug agreement, have quit contract practice and moved. One local, which made such unreasonable demands upon its doctor that he withdrew, is now forced to get along with an osteopath and to pay him $3 a month per family instead of the $2 it paid its medical practitioner. Evidently, such incidents have alarmed UMW headquarters, for word has been quietly circulated among local officials to "lay off the doctors," for the time being.

Contract physicians are in the anomalous position of making more money each year than the average doctor yet of getting a far-below-normal return for each call they make. A contract practitioner with a panel of 1,000 miners and their families will gross about $24,000 a year, but he will work so hard

[*Continued on page* 192]

AMCP Faces Difficult Role in Prepay Plan Coordination

Period of inaction past for central agency of voluntary insurance movement

Since last February, Associated Medical Care Plans, Inc., AMA-sponsored agency to coordinate voluntary health insurance plans, has been featured as medicine's answer to compulsion. Actually AMCP has been stalled for six months over one issue: Should medical-society-approved plans underwritten by commercial insurance carriers be accepted into the non-profit fold?

Last month at its first annual meeting, AMCP paved the way for long-needed acceleration of the prepay movement. Delegates from 14 of 25 states represented voted not to exclude any medical-society-sponsored plans because of commercial tie-ins.

Plan managers in many states had threatened to withhold their cooperation if profit-making plans were accepted. But because it later appeared that plans operating in several states might be forced to call on commercial companies for assistance, the non-profit criterion was abandoned.

Before the end of the year Wisconsin's commercially backed plan will probably apply for membership in AMCP, thus creating a test case. Taking its cue from opinions expressed at Chicago last month, the AMCP commission is expected to approve the application. Other plan managers, despite their former vehement opposition to Wisconsin, are now coming into the organization.

AMCP had nine charter members on Oct. 1. It is expected to have twenty-five members by Jan. 1. It has a potential membership of forty-four.

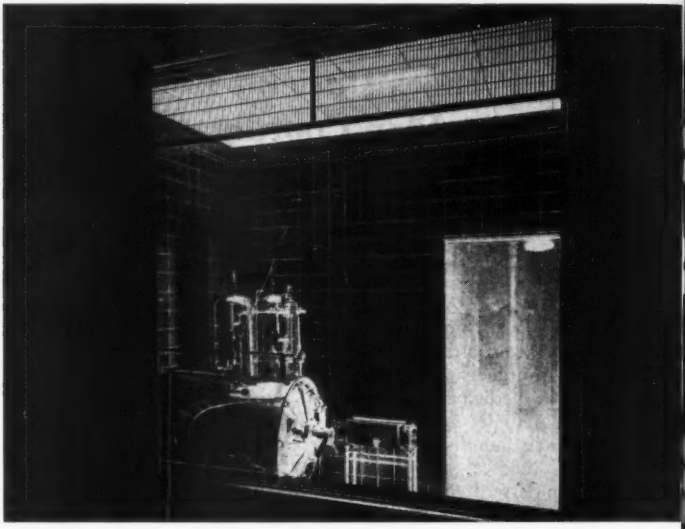
Many plan managers took home from Chicago a "watch-our-smoke" optimism; but few overlooked these unsolved problems which still face AMCP:

¶ How to extend voluntary health insurance into the fifteen states that do not now have any plan. To encourage the launching of new plans is a responsibility of the AMA Council on Medical Service; but some plan managers feel that AMCP must do the job.

¶ How to increase enrollment now estimated at 5 million people. Although the ultimate objective is to enroll in excess of 70 million, the immediate hope of the men actually enrolling subscribers is that another 2 million can be signed up by March 1947.

¶ How to get more comprehensive benefits for subscribers. Some plans, Washington's and Oregon's

[*Continued on page* 119]



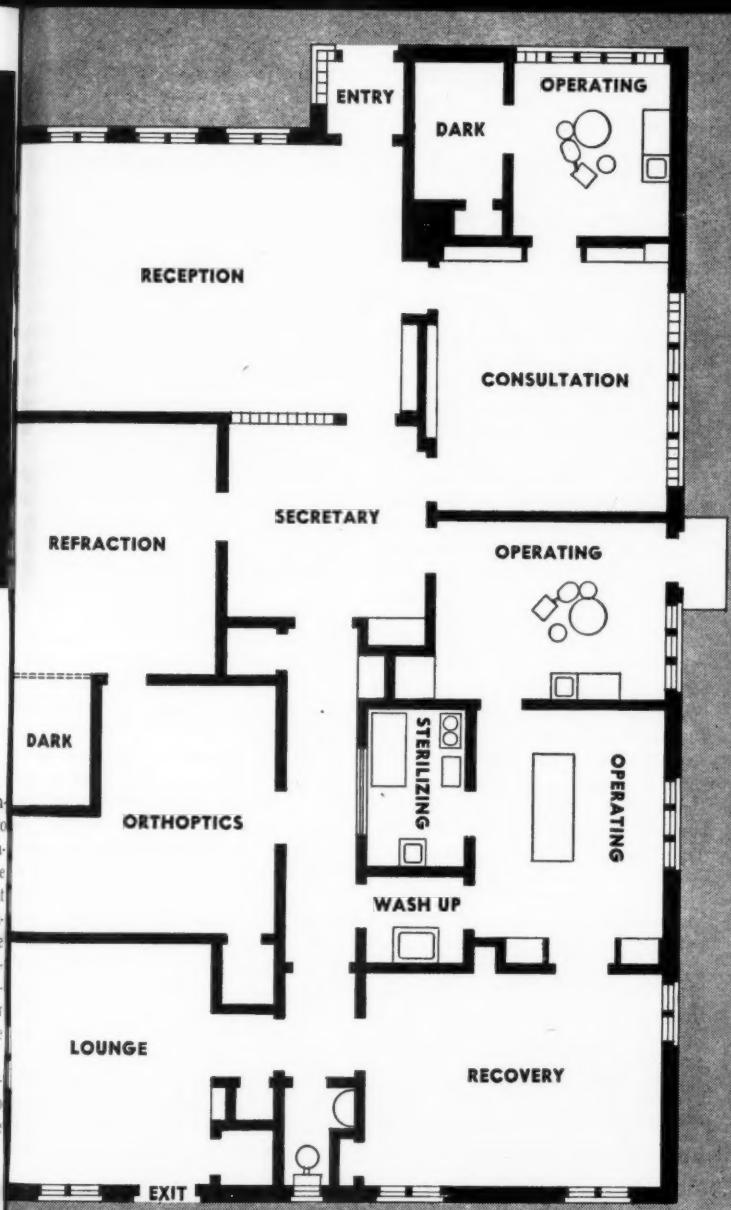
Layout for an OALR Office

Dr. Nathaniel B. Cole has developed for his office in Perth Amboy, N.J., a floor plan that is well suited to his OALR specialty.

Design emphasis is on the facile movement of patients through the building. From the reception room, they proceed into the secretary's glassed-in compartment for case-history privacy. The aide has a direct view of the office's entryway from her working compartment. When not occupied with record details, she can greet patients at an informal auxiliary desk located in the reception room.

From the secretary's central compartment, patients are directed to the required treatment or consultation room without reentering the reception area. A separate exit at the building's rear enables the patients to move through the office constantly without creating any disturance. In the recovery room, diathermy equipment is installed for the patients' use while they are resting after treatment.

The well-knit pattern of treatment rooms permits Dr. Cole to give treatments to as many as five patients at a time.


ENTRY
DARK
OPERATING
RECEPTION
CONSULTATION
SECRETARY
REFRACTION
OPERATING
DARK
ORTHOPTICS
STERILIZING
OPERATING
WASH UP
LOUNGE
RECOVERY
EXIT

Report on a College of Osteopathy

A physician finds first-rate equipment but inadequate clinical training

[EDITORS' NOTE: The September issue of MEDICAL ECONOMICS carried a letter to the editor from an M.D.-D.O. who severely criticized osteopathic methods of training. Prepublication proofs were sent to other M.D.-D.O.'s, including Dr. Alden Q. Abbott, president of the Massachusetts Osteopathic Society, who replied, in effect, "Your correspondent is misinformed. For the sake of your readers generally, why not assign a competent investigator to visit a first-rate osteopathic school in person—say, the Philadelphia College of Osteopathy?" Taking Dr. Abbott's suggestion, MEDICAL ECONOMICS arranged just such an inspection. The investigator is a physician, holds a responsible position in a large medical society, and is a faculty member of an approved medical school.]

As far as its physical facilities and scientific equipment are concerned, the Philadelphia College of Osteopathy is adequately fitted to teach medicine. Its students hold either the pre-professional qualifying certificate of the State of Pennsylvania or the medical qualifying certificate of the New York State Department of Education.

With the exception of the number of hours devoted to clinical work, PCO's curriculum parallels that of most medical schools. Only 16 per cent of the schedule is devoted to clinical work as contrasted with an average of 27 per cent in approved medical schools.

A relatively small amount of time is devoted to the doctrine of spinal manipulation. With this time subtracted, the remaining schedule compares favorably, hour by hour, with the schedules of medical schools. Fifty-one textbooks are required and only three of these are peculiarly osteopathic. The other forty-eight were written by M.D.'s and are the standard editions used in schools of medicine.

Of all osteopathic training institutions in the country, only seven are classified as approved schools. Among these, the schools at Los Angeles and Philadelphia claim the widest legal recognition. Approved osteopathic schools are, in effect, legally on a par with the best medical schools. In thirteen states, the graduate of an approved school of osteopathy is given a full license to practice medicine and surgery on passing state board examinations.

Although most M.D.'s condemn osteopathic education as substandard, few such critics have ever seen the inside of an osteopathic school. I spent quite a few hours at the

Philadelphia institution. The school and its hospital are housed in adjacent wings of a million-dollar, Gothic-style brick building in residential West Philadelphia.

The principal operating room of this 175-bed hospital is situated in the well of a beautiful clinical amphitheatre—the gift of Atwater Kent. An abdominal operation was in progress during my visit, and the general picture presented by the surgeon, assistant, anesthetist, nurses, and equipment was identical to the scene in any modern operating room. I inspected the sterilizers, anesthetic equipment, and instrument supply and found them in keeping with what one would expect in any hospital. I leafed through a number of patients' charts. The history, findings, progress notes, and laboratory reports in each case were well written. Nothing in any of the records would have distinguished them from records found in most hospitals.

I examined the diet kitchens, X-ray department, delivery room, nurseries, laboratories, and autopsy room. None of these would have been out of place in any hospital; nor was there any noticeable lack of the other equipment normally found in a 175-bed general hospital.

I could not gauge accurately the quality of medical care given, but emphasis appeared to be on medication, diagnostic instrumentation, and therapeutic surgery rather than on physiotherapy or spinal manipulation. The quality of care depended obviously on the quality of the practitioners, and since most of them were alumni of the adjacent college, I turned my attention to the school building and schedule.

LIBRARY

The library is a small room lined with shelves housing about 2,000 books. Dean Otterbien Dressler estimated that including the books in the storage stacks, the library numbered about 5,000 volumes. Most of the books visible were written by

Philadelphia's College of Osteopathy teaches little manipulation, much basic medicine.

M.D.'s. They included the standard texts advertised in our own journals and issued by the major medical publishing houses. There were few peculiarly osteopathic books. Bound copies of such periodicals as "Medical Clinics of North America" and the specialty "Year Books" occupied the first bookcase. Scattered on the tables were recent issues of the JAMA and of most of our reputable specialty journals.

REQUIRED TEXTS

Books in use, dealing with the specialties and with the basic sciences, were texts written by M.D.'s. In the dissecting room, I saw students using Cunningham's classic dissection manual. At another table, cross-sections of tissue were being compared with the standard cross-section atlas. The regular anatomy text was the latest edition of Gray. On a hall table, one student had deposited DeLee's "Obstetrics," Sutton's "Dermatology," and Christopher's "Minor Surgery." In the posted list, under the subject "osteopathy," the required books were Norris and Landis' "Physical Diagnosis," Todd and Sanford's "Clinical Laboratory Methods," and Cecil's "Medicine." Why such volumes should be considered books on osteopathy is hard to understand until one realizes that the current osteopathic philosophy is that modern medicine is really osteopathy and that the doctors of medicine have at last caught up with the osteopaths. The required text in therapeutics, however, is Sollman's book on that subject.

SCHOOL FACILITIES

The dissecting room was clean and free of offensive odors. Bodies were in good preservation. Four students were assigned to each cadaver. The anatomic specimens on display had been carefully prepared. The wall charts were those used in regular medical schools. I did not see any of the elaborate nerve and spine diagrams which delight the chiropractor.

A woman instructor was demonstrating to a small group of students the internal anatomy of the brain stem. She was holding a partly dissected medulla and was identifying the tracts and nuclei. In a nearby classroom an instructor had projected an X-ray film of the chest and was demonstrating the heart contour. The pathologic laboratory seemed thoroughly modern with a microscope for each student and adequate facilities for staining, fixing, and slicing tissues. In the school building were rooms containing basal metabolism, X-ray, fluoroscopic, and electrocardiographic equipment.

THE CURRICULUM

The entire osteopathic training course is a four-year program aggregating 4,710 hours. Of these only eighty hours (all didactic) are devoted to "osteopathic principles." To be sure, the word "osteopathy" appears in other parts of the curriculum, but inspection of the content shows that such subjects are the ordinary therapeutic and practice-of-medicine courses found in all medical schools. After subtracting the eighty hours of osteopathic principles, there remains a course totalling 4,630 hours. This is about the same as the time allowance in the regular medical schools in Philadelphia where the courses average about 4,500 hours.

At PCO the breakdown is: 2,576

hours of didactic lectures, 1,386 hours in the laboratory, and 748 in clinical work. This highlights one major weakness of the course: its small proportion of clinical time. In the University of Pennsylvania School of Medicine, less than a mile away, the curriculum includes 1,185 clinical hours; and across the river at Jefferson Medical School, 1,150 clinical hours. The accompanying table shows how these two recognized medical schools compare with PCO in breakdown of clinical hours.

FACULTY

Of the 135 members of the faculty, 129 are doctors of osteopathy. One (a clinical assistant in otolaryngology) has no degree; one (associate professor of chemistry) is a B.S.; and one (lecturer in oral hygiene) is a DDS. The professor of surgery is listed as "M.D., D.O." The lecturers in pharmacology and in tropical medicine are M.D.'s. Since an osteopath would not be permitted to teach in a regular medical school, obviously members of the PCO faculty (with few exceptions) would not be eligible for any kind of teaching position at an approved medical school.

STUDENTS

The college has 300 students, the ratio of instructors to students being about one to two. This is substantially the same as at Jefferson Medical College which has 300 instructors for 600 students. The class

BREAKDOWN OF TOTAL CLINICAL HOURS IN A FOUR-YEAR CURRICULUM

Subjects	Hours per School		
	Pennsylvania	Jefferson	PCO
Surgery and urology	296	274	180
Medicine and dermatology	483	489	352
Orthopedics	12	30	32
Obstetrics and gynecology	130	140	80
Eye, ear, nose and throat	50	70	32
Neurology and psychiatry	40	70	24
Pediatrics	144	77	48
Total clinical hours	1,185	1,150	748

This table is based on an analysis of schedules as they appear in the several catalogues. In some instances, descriptions did not permit an unequivocal conclusion as to how the hours should be scored. Is a "clinical lecture" really a lecture using a patient for public demonstration (in which case it is a didactic hour) or does the student actually examine the patient? In PCO all hours were labeled "didactic," "laboratory," or "clinical," and these allotments were used in the table. In the other schools, doubtful hours were counted as didactic; hence, the medical schools may provide somewhat more clinical hours than those listed in the table.

Handitip

Nose-Counter

Ever had trouble pacing your work because you didn't know how many patients were waiting? A Colorado doctor found this troublesome. He solved it by mounting in his treatment room a needle-type fuel gauge from an old Ford. He wired it to a small transformer and an adjustment rheostat sixty-five feet away in a 3"x5" box on his secretary's desk. Now a simple twist of her wrist tells the doctor just how many cases are waiting. He takes extra time when he has it, pours on the coal when the backlog mounts.

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that entered PCO in 1944 numbered sixty-eight. A check of their preliminary training shows that thirty had had only two years of college and fifteen had had three years. However, twenty had B.A. or B.S. degrees and three had master's degrees. Analysis of the corresponding class at Jefferson indicates that 105 out of 153 had bachelor's degrees. It seems reasonable to conclude that while students at this leading osteopathic institution are not so well educated at the premedical level as those who are attending approved medical schools, they are far better educated than might have been expected. The twenty-three osteopathic students with baccalaureate or higher degrees came from reputable colleges. Their alma maters included Columbia, Fordham, University of Pennsylvania, New York University, Harvard, and others of similar standing.

RESEARCH

One serious research project in caudal anesthesia is in progress, but otherwise I saw no indication of research activity. The dean asserted that this department was being revised and would soon be conducted more intensively.

DOCTRINE

Dean Dressler insisted that his school continues to teach the original Still doctrine, including the thesis that spinal manipulation is necessary "or at least helpful" in all disorders. He put much more emphasis, however, on other aspects of osteopathic philosophy, underlining especially the concept that drugs "produce a favorable internal environment." This he contrasted with the idea that drugs "cure" disease, which he said was the thesis of most M.D.'s. In an article some time ago, Dean Dressler said, ". . . every time anyone uses a vaccine to develop immunity within the body, he is practicing osteopathic medicine; when he uses diphtheria antitoxin, he is practicing osteopathic medicine."

It was my impression that this school clings to spinal manipulation as an historical whimsy without allowing it to interfere with modern treatment methods. This conclusion is based on the little emphasis placed on spinal manipulation in the curriculum and on the extensive use of medication and surgery evidenced by the teaching program and clinical records. Ingenious rationalizations are required, and found, to fit the spinal manipulation thesis into a modern medical approach.

How You Can Get More Out of Medical Society Meetings

These tips will help to make such sessions a source of useful knowledge

The speaker for tonight is an eminent specialist. For weeks we have looked forward to this particular meeting of our county medical society. When the business session has been completed, we sit back in our chairs, eager to hear what promises to be an interesting paper.

For the first few minutes we are closely attentive. Then a dull passage or two causes our interest to wane a bit. Our mind begins to wander. Before we know it, we are consoling ourselves with the thought that we can read the paper when it is published; and by the time the discussion period begins, we are hoping that it is mercifully short so that we can either get home or at least be free to enjoy the usual post-meeting collation.

Why do so many of us get so little out of medical society meetings?

In most instances, it seems to me, the trouble lies less with the speaker than with us, his listeners. We go to the meeting prepared only to hear, not to learn. We take no part in the discussion. We contribute nothing but our presence. As a result, we come away disappointed. Actually, a series of good scientific meetings can be as useful as an expensive post-graduate course—if we help to make it so. Many a progressive-minded M.D., by regular attendance and a little private effort, has been able over the years to accumulate a highly practical backlog of medical information.

First, let it be remembered that the man who takes notes is bound to absorb more knowledge than the one who merely stares into space. Under the self-imposed discipline of note-taking, the hearer listens more carefully, thinks more logically, and retains what he hears more surely.

The first step is to come prepared to take notes. Bring along notepaper or cards. Don't depend on a frantic, last-minute search through your pockets for an old envelope. A pocket-size notebook, which costs but a nickel or dime, is preferred by some; others use 3" x 5" cards (or slips of paper) which can be held together with a rubber band.

A little preliminary reading is another means of making the evening more fruitful. If, for example, the announced subject is thyroid disease, an hour spent reviewing the indications for medical treatment and the contra-indications for surgery (or a half hour spent tabulating the more common post-operative complications) will

provide a springboard for asking intelligent questions.

The experience of getting to one's feet and asking a question or two is always stimulating—particularly for those who have never tried it. Speakers appreciate it, too, for nothing deflates a lecturer more thoroughly than a deadly silence when the moderator asks, "Are there any questions?"

Often it's not wise to put off questioning the speaker until after the meeting, in the hope of talking to him privately. He may be busy with some society officer or in a hurry to catch a train.

Some speakers, in describing a new treatment, fail to mention exact dosages and methods of administration. Such omissions provide an ideal opportunity for the attentive listener to ask worthwhile questions.

It is perfectly proper to write to the speaker if, in trying to put his suggestions into practice, you find that results don't quite equal those reported in his paper. Be sure, however, that you first give him all the facts about your case, then ask his advice. Such correspondence often leads to a friendly relationship. Moreover, it may serve a useful purpose in furthering your medical knowledge.

If the lecturer presents an important new therapeutic development, the wide-awake listener will do more than make a note: Next day, he will make a marginal reference in his office textbook on that particular subject. Suppose the speaker has reported that a new drug, glutamic acid, has proved effective in epilepsy. Your textbook mentions only bromides, dilantin, and barbiturates. Jot down in the margin, "Try glutamic acid," and give the dosage. (Or a similar note may be entered on the "Epilepsy" card if you maintain a card index of diseases and therapeutic procedures therefor.)

Tackled in this fashion, medical meetings will quickly cease to be the dull, disappointing affairs which you may have come to regard them, and your regular attendance will begin to yield a fund of useful knowledge.

—HENRY A. DAVIDSON, M.D.

Assault with Battery

It was my first case as an interne. Wearing an immaculate new interne's jacket and my best professional manner, I bent over the ward patient with a brisk "H'mm, so you're developing a sore throat?" Looking on from the other side of the bed were a veteran nurse and a trainee. With an expert flourish, I placed the tongue blade in the patient's mouth, aimed my new flashlight, and pressed the button. Before my horrified gaze, the front end of the flashlight, the lens, bulb, and both batteries popped onto the patient's face. —A. J. NICHOLAS, M.D.

Answering the Patient Who Asks 'What Will It Cost, Doctor?'

Maximum and minimum estimates help to keep patients informed

Mention an operation, a series of office treatments, or a diagnostic work-up at the hospital, and the patient may well ask (or wonder), "How much is all this going to set me back?"

If he asks and you answer evasively, he may go elsewhere. If he doesn't ask and you fail to give him some idea of the cost, your bill may surprise him—and go unpaid while he tells the neighborhood what "a robber" you are.

On the other hand, a too precise estimate may be as troublesome as one which omits consideration of hospital costs, medicines, X-rays, or other special items.

Some physicians feel that no practitioner should voluntarily mention the matter of remuneration. But many hold that a mutual understanding regarding fees and additional expenses between doctor and patient should exist before treatment is begun. Some believe that this understanding should be based upon (a) utter frankness, (b) a minimum and a maximum estimate, and (c) the assurance that everything possible will be done to speed the patient's recovery and thus minimize his expense.

Several physicians who were interviewed recently indicate that a fair degree of tact and a wholehearted effort to "see yourself as patients see you" can do wonders to help in answering the often-embarrassing question, "How much, Doctor?"

One physician reasons this way: "Unless a patient knows in advance what a prolonged course of treatments is going to cost, he may hesitate to come back as often as necessary. Or he may drop the treatments before I can do him any real good."

Another says, "Patients who are given a fair minimum and maximum estimate are usually able to arrange their budgets to pay a just fee—particularly if I indicate a willingness to accept time payments. In the event that I find it unwise to give an estimate, I assure the patient that I will make every effort to minimize the number of calls and that my fee will be as reasonable as possible. The word 'reasonable' usually dissipates fear of a heavy bill."

"I always put surgical estimates in writing, give the patient a copy, and keep a copy for myself," one physician points out. "I list not only my fee, but all extras—hospital room, operating room, anesthesia, special nursing, X-ray, laboratory

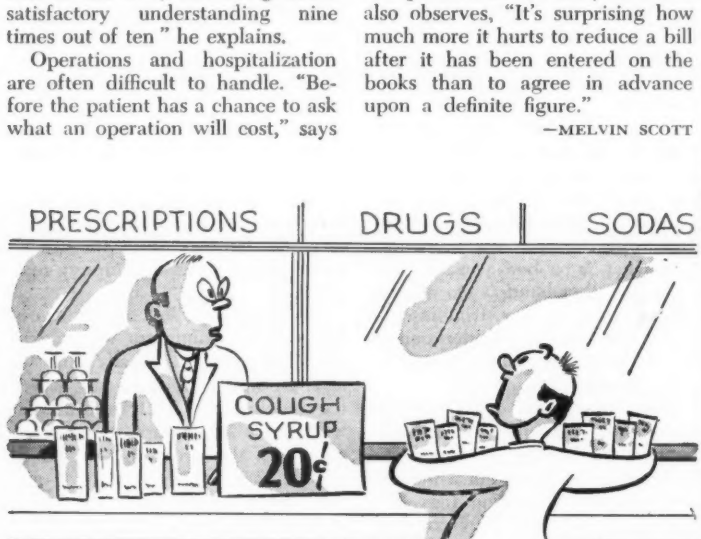
tests, and all other expenses."

One specialist thinks that no matter how high it may seem to the patient, any quoted figure is better than none, and that hearing a definite estimate does away with uncertainty. He feels that usually if the patient can't meet the fee he'll say so and provide some legitimate grounds for compromise. "Suggesting a time-payment arrangement, a slight reduction, or a combination of the two, can bring about satisfactory understanding nine times out of ten" he explains.

Operations and hospitalization are often difficult to handle. "Before the patient has a chance to ask what an operation will cost," says another specialist, "I ask whether he wants private or semi-private accommodations, and whether or not he wants a private nurse. His answer gives me something concrete to follow in quoting a fee. Any patient who is frank enough to discuss fees in advance of treatment is seldom a trouble-maker in paying his bill."

All doctors interviewed agree that patients appreciate having the fee question settled early. But one also observes, "It's surprising how much more it hurts to reduce a bill after it has been entered on the books than to agree in advance upon a definite figure."

—MELVIN SCOTT



"I LIKE IT ON MY PANCAKES!"

AMA Delegates Face Lively Session

Rich report, prepay lag, veterans' care share top billing on December agenda

Organized medicine's elected representatives, 175 strong, will cram Chicago's Palmer House next month for an AMA House of Delegates meeting. Observers forecast a medico-political battle royal.

From December 9 to 11 the AMA will hold the first of the interim meetings prescribed last summer. "The House has so much business to transact that delegates don't have time to give it proper attention at a once-a-year convention," Dr. George F. Lull, AMA General Manager, explains. December's session will be stripped of scientific meetings and side exhibits, leaving medicine's policy-makers free for full-time debate.

Topping the agenda is the report of Raymond Rich & Associates, an able critique of AMA public relations which the Board of Trustees has released only in part. AMA officers announce that the complete text will be made available to delegates at the December session. Says Dr. William Bates of Philadelphia, chairman of the delegates' committee which is studying the full report: "My own feeling is that even the mention of that report before it's been considered by the AMA is in poor taste. I know that the West Coast has jumped the gun on it, but my committee has nothing to say until December 9th."

This secrecy has put a keen edge on most delegates' curiosity. Physicians interviewed by MEDICAL ECONOMICS express some resentment over the handling of the matter. Says one: "I've noticed a swelling tide of criticism in state and county journals over the withholding of the Rich report. Looks like fireworks in December." Another delegate remarks: "In all fairness, we'll have to consider the report with candor to decide whether it is advisable to bring it into the open." Says a third: "The point is, does the House of Delegates have the final say in establishing AMA policy, or does the Board of Trustees?"

AMA delegates predict that the December session will also concern itself with:

¶ The lag in AMA promotion of voluntary prepayment plans, and what can be done to push development before a revised Wagner-Murray-Dingell bill finds its way into the Congressional hopper.

¶ The pattern veterans' care plans should take. Says one delegate: "Doctors are beginning to realize the importance to themselves of a good veterans' care plan. The last convention did practically nothing about it. By December,

state plans will have rolled up valuable experience on which to base a pattern."

¶ Medical and welfare plans of labor unions. One state society officer comments: "The significance of those contracts only began to dawn on medical men after the July convention. They want some sort of report on how such plans affect physicians."

¶ The profession's answer to the renewed threat of Federal medicine. Delegates want to know the results of conferences between Senator Robert A. Taft and the Council on Medical Service, slated for early this month.

¶ Group practice. Says one delegate: "It's time we considered whether group practice should be more specifically recognized by the AMA. The people in groups are working for a solution to health problems through voluntary methods. We should recognize the fact that they're on our side of the fence."

¶ Inquiry into physicians' military rank. M.D.-veterans, at least, have not forgotten the investigating board authorized at San Francisco—nor has it escaped their notice that the board had not even been appointed by summer's end.

—JOHN BYRNE

"HE USED TO BE A PEDIATRICIAN."

Sculptured cast bronze, gold leaf lettering on both sides distinguish this post sign.

Illuminated sign with name on both sides can be used as wall sign without scrolls.

Personalized shingles denote physician's hobby or activities of the community.

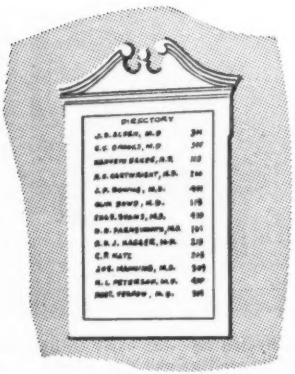
Silhouettes of childhood scene animate this lighted sign made for pediatricians.

SUBJECT:

Signs

Here is a variety of personalized "shingles" to satisfy your aesthetic sense or even your hobby. They are adapted to different types of locale and architecture. Many of these signs were designed especially for MEDICAL ECONOMICS, to challenge the artistry of your local woodworking or sheetmetal shop

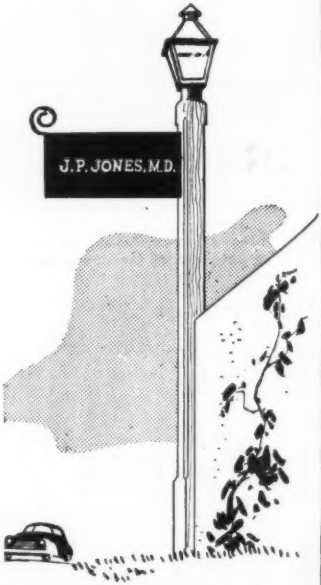
Credits: Page 73, top left, lower right (p. 75 middle left), Spencer Studios, Inc.; top right, Westfield Studios Inc.; lower left, Whitehall Metal Studios, Inc.; original designs pp. 74 and 75 by John G. Shea.



Broken-pediment colonial plaque provides space for roster of a medical building.

Rustic lamp post with broken-board panel picks up atmosphere of wooded locale.

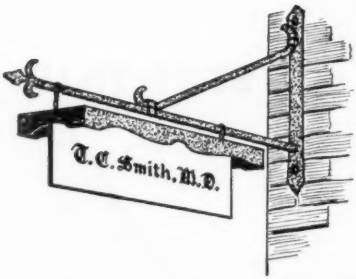
Stainless-steel lettering mounted on wall bracket blends with modern architecture.



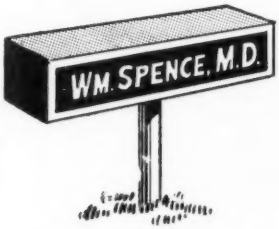
Antique post lantern, electrically wired, illuminates metal or wooden sign plate.

A stork perches before the obstetrician's office. Metal or wood used in construction.

A scalloped metal hood conceals fluorescent light on this simplified wall sign.

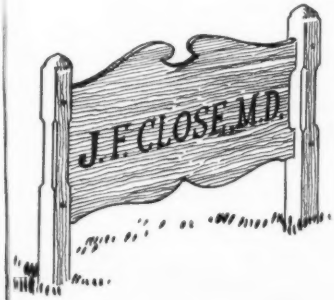


Antique details distinguish illuminated bracket sign of wrought iron and wood.



Lawn marker can be read from both sides. Waterproof electric cable used in wiring.

Mounted behind an opening in your door, glass panel is lighted from rear.



Colonial scrolls, pegged posts harmonize sign with early American architecture.

Identification is positive when your shingle hangs on wood or metal caduceus.

STOP THIS

"Disastrous results" of self-medication with thyroid preparations have been stressed. (Bureau of Investigation: J.A.M.A. 129:904 (Nov. 24) 1945). Following the patient's first exposure to ordinary desiccated thyroid, he readily recognizes its characteristic qualities and may demand and sometimes receive large quantities of such preparations without medical sanction. For

SAFETY

a. Proloid being purer, and free from unwanted organic matter, has neither taste nor odor identifiable by the patient.
b. Nor can it be identified as thyroid by name.
c. The greater uniformity of metabolic activity with Proloid favors a more even, less fluctuating stimulation. (Proloid is standardized by a metabolic assay as well as U. S. P. assay.)

PROLOID

The Raltine Company • NEW YORK 22

Five Checks on Delinquent Accounts

Mercantile credit managers employ these fundamental collection rules

Some time ago a physician I know turned over to me a long list of delinquent accounts; all of them, he felt, represented dyed-in-the-wool "deadbeats." Yet within two weeks, by applying five simple collection fundamentals, I began to receive payment on a substantial percentage of these bills.

From a small town in Texas came a money order, from Virginia a check, from Massachusetts a registered letter with money enclosed. In none of these cases had the doctor known that the patient had moved to another state.

Dozens of other patients still living in town either paid something on account or sent letters of apology promising that they would settle in full or in part after they had received their next pay envelope. A railroad ticket agent who owed $150 for an operation said that he had been ashamed to admit that he couldn't afford a lump-sum settlement, and hadn't realized that the physician would accept installments. He welcomed the chance to settle at $10 a month and never missed a payment.

Here are the five fundamental rules which I employed and which you also can use in collecting delinquent accounts:

1. *Be sure that you have the patient's present address.* Statements forwarded from an old address have a bad psychological effect on a debtor. Often he says to himself, "The doctor doesn't even know that I have moved; I can pay him next month just as well. This month I'll pay off the finance company or they'll take my car. They know where I live." If such a patient has moved to another town, he may resort to this line of reasoning indefinitely as monthly statements continue to be forwarded to him. On the other hand, a brief note addressed to his present home or his present place of employment makes him much more conscious of his unpaid obligation. Then he is less likely to delay settlement or to attempt to escape it altogether.

2. *Find out specifically* WHY *the patient hasn't paid.* Only in a small percentage of cases is failure to pay due to deliberate dishonesty. Usually the patient's limited monthly income is either badly budgeted or not budgeted at all. Often, creditors such as retailers or landlords, who are most insistent on having their bills paid promptly, get first consideration. The debtor is well aware that an automobile or fur coat bought on the installment plan may be taken away if payments are not made regularly, that his light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MUSCULAR ACHES
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ABSORBINE JR.

and telephone service may be discontinued because of delinquency, and that he may be dispossessed for unpaid rent. If the physician knows exactly why the patient has been delinquent, it may be possible to arrange for monthly payments on account. That way the medical bill gets its rightful share of consideration with the debtor's other obligations.

3. *Send a reminder a few days before the next statement goes out.* Preparing the debtor to expect a bill is infinitely better than dunning him later. A note which acts as a memory jog (not a dun) should help him to plan so that he can include your payment among his next week's expenditures.

4. *Contact the patient promptly when a promised payment has not been made.* Failure to pay at a promised time should not pass unnoticed; within a few days, the debtor should be informed that his neglect has not been overlooked. Payments of less than the promised amount should also be brought promptly to his attention. Experience in mercantile collections has proved that firmness prevents many a delinquent account from becoming a bad debt.

5. *Find out where the patient works and when he is paid.* Delinquency often begins with unemployment or when a man changes jobs. Sometimes the first few weeks on a new job mean large deductions for union dues or employment-agency fees. Or a new job may mean semi-monthly instead of weekly pay days. Job changing may entail moving expense. All such factors could delay payment of a medical bill; but if the doctor keeps tabs on the man's employment whereabouts, collection arrangements are much easier to make. Occasionally a note to an employer will result in immediate payment of a long overdue account.

—MILWARD PICK

Say Uncle!

A physician friend of mine decided that if he could teach his juvenile patients to call him "Uncle George" it would overcome their fear of seeing the doctor. He put on a vigorous campaign to that end. One day the physician was late getting to his office. In the waiting room sat six children, each accompanied by his mother, and one solitary man. When the physician entered, he was greeted with a loud chorus of "Hello, Uncle George." One by one, he took care of each child patient, who then departed with the usual "Goodbye, Uncle George." Finally the physician got around to the solitary man. "First time I've been here in three months," the patient said ruefully. "Just my luck for you to have all your relatives in today."

—CHESTER L. DAVIDSON, M.D.

Taft Maps Offensive Against Nationalized Medicine

Warns M.D.'s against false optimism, notes "negative attitude"

Legislation designed to promote better medical care is no novelty. Bills have been introduced in the past to encourage research, to aid in the construction of hospitals, and to expand public health work. But now public interest is centered on proposals of a much more extensive nature.

The Wagner - Murray - Dingell bill is an example. It would provide compulsory sickness insurance for everyone in the United States. Long hearings have been held on it. Extensive propaganda is being carried out in favor of it. Undoubtedly it will be presented to the next session of Congress and a determined effort will be made to secure its enactment. President Truman has officially endorsed it, so that it has become one of the projects of the present Administration.

▶ Senator Robert A. Taft, author of this significant article on improving medical service, is known to physicians as a leader in the fight against Federal medicine. Reprints of his analysis may be obtained from MEDICAL ECONOMICS in lots of fifty or more at two cents apiece.

The proponents of this bill seek to create the impression that it would provide just a form of insurance similar to life or hospital insurance or any of the other kinds of insurance. But it would not. It is a plan for Government administration of all medical care, supported by a tax on payrolls and Federal subsidy to cover deficits.

This can't be insurance if a man has no option except to pay for it. Even the International Labour Office (a leading proponent of sickness insurance) admits this. It says:

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service. It squeezes out most of the private practice on the one hand and most of the medical care hitherto given by the public assistance authorities on the other. The next step to a single national medical service is a short one . . ."

Since the tax is based on a percentage of payrolls, it relates to the income of the employe and not to the service performed. The man with a low income and a number of dependents pays less for more

37% Stronger for Coughs

Exempt Narcotic

Each fluid ounce contains (1) one grain Codeine Alkaloid

MADE with the Codeine *Alkaloid* one grain to the ounce. It is readily verified that 1 grain of Codeine *Alkaloid* is equal in strength to 1.37 grains of the commonly used Codeine Phosphate.

A palatable, cherry-colored syrup, well tolerated by children. Contains with the codeine; ammonium chloride, ipecac, glycerine, sugar, water, flavoring and senna. An exempt narcotic. Costs little or no more than ordinary codeine syrups. Druggists stock for prescription use. *Prescribed since* 1898.

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If you will try it —just once—in the coughs of pertussis, bronchitis or asthma—you will continue to prescribe it and we shall be grateful.

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Hollings-Smith Co. Orangeburg, N.Y.

service than the unmarried man with higher income. This is a principal of taxation, not of insurance. A compulsory levy of this kind is a tax because it deprives the employe of his freedom of choice in spending the money he earns.

Under the terms of the Wagner-Murray-Dingell program, from three to five billion dollars would pour into Washington each year. A Federal bureau with branches in every town and city would pay all doctors to render without charge the medical service required by all citizens. The Government would issue regulations determining who was entitled to medical care and whether it was to be given in hospitals, in doctors' offices, or in patients' homes.

Regulations of many kinds would be necessary, for the Government could not spend unlimited amounts simply because the patient or the doctor asked for more care than was reasonable Regulations would limit the prescription of items such as expensive medicine and X-ray services. Regulations would specify whether doctors were to be paid on a per capita basis or on a service basis, and how much they should receive. Thus, the Wagner-Murray-Dingell program proposes, first, a socialization of medicine and, second, a transfer of all control over health activities from the states and local Governments to a Washington bureau.

It does not necessarily damn a program to call it socialization. We

"WELL, HOW ARE WE TODAY?"

have long socialized primary and secondary education. Education, however, is very different from medicine. The service to be performed can be reasonably adequate in the lower grades even if it is practically uniform for all students. A primary education must be compulsory for every boy and girl in the nation, and education through private schools cannot begin to do the job.

Free medical care presents much more difficult problems than free education. Every case requires special treatment, and every individual should have the choice of paying for more or less medical care, as he chooses.

The fact that we have socialized education cannot be used as a precedent for socializing every other field, or we would soon have a completely socialized economy. If we are going to give free medical care to all people, why not provide them with free transportation, free food, free housing, and free clothing—all at the expense of the taxpayer? Socialization implies a question of degree, and we cannot move much further in that direction unless we are willing to accept a completely socialistic state.

I have seen no evidence that existing systems of compulsory health insurance provide as high a standard of medical service as is now found in the United States. Nor is there any conclusive evidence that the lowest income groups are better served under such systems than here.

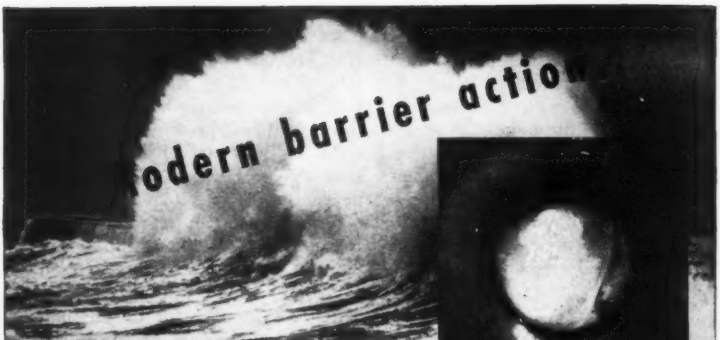
I am strongly opposed to socialization of medical care except for those unable to pay for it. If

the people of a state desire to socialize medicine, that is their privilege. But what possible justification can there be for giving a Washington bureau the power to employ all physicians throughout the nation? Such a thing has not been done even in education. Our people in each state and in each school district have retained complete control over the education of their children and over the employment of their teachers. In most states the system has been separated from political government as it could never be separated under the present organization of the Federal Government.

Any attempt to regulate the affairs of all the people in all the states is usually tyrannical and inefficient. Conditions vary in the different sections of the country. No man, certainly no Federal bureaucrat, knows enough to draw regulations which fit all those conditions.

The average man has no voice in the operation of a Washington bureau. In his own city council or state house he can make himself heard by appearing in person. He can write letters to the newspapers. He can run for office himself and present his program in an election. But in Washington he often cannot even find the bureau or the man supposed to handle his problems. The general attitude there is that the public is "too damned dumb" to understand anyway.

The political patronage inspired by a Wagner-Murray-Dingell program would be tremendous. To operate the machinery required



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would take anywhere from 250,000 to 1½ million employes—in addition to the medical profession. More than 50 million cases would have to be checked every year as a basis for payment and statistical information. Federal bureaus of this nature are notoriously inefficient, expensive, and political. The medical bureau would have to send investigators into every home. It is hard to conceive any function which would touch more closely the lives of our 140 million people.

Already, we have moved so far toward a totalitarian state that our people risk losing completely the liberty for which we have fought two great world wars. This is the basic issue today in most legislation that comes before Congress. We must determine whether we are going to progress along the lines that have made this country the greatest in the world or whether we are going to turn over our destiny to a bureaucracy of self-styled experts. I cannot conceive a measure which would more surely lead to an all-powerful central government than Federal compulsory health insurance.

The claim is made that medical service in the United States today is inadequate. Extensive evidence has been offered to prove that point. I am not sufficiently expert to judge the truth of these claims. One fact, however, stands out: The health of the United States as a whole is as good as that of any nation and better than that of most.

We must of course recognize that there are gaps in the service

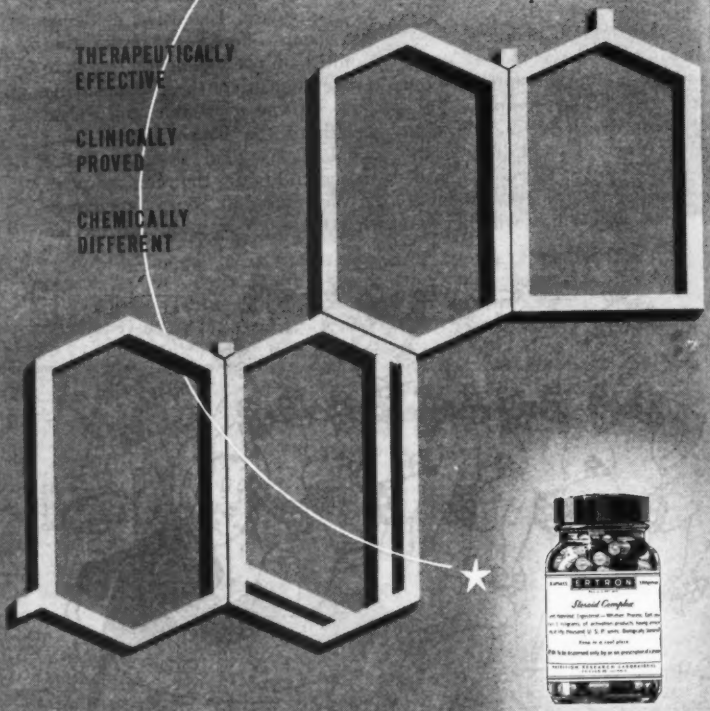
"SAY, ISN'T THAT ONE OF STREECH'S HYSTERECTOMIES ON THE LEFT?"

What to expect of st

THERAPEUTICALLY EFFECTIVE

CLINICALLY PROVED

CHEMICALLY DIFFERENT



steroid therapy in arthritis

The findings of various investigators indicate that beneficial effects of Ertron—Steroid Complex, Whittier—are due to its systemic action. Under the regime of steroid therapy in arthritis as provided by Ertron, clinicians frequently observe in patients such subjective and objective responses as:

- Recession of pain
- Diminution of soft-tissue swelling
- Increased motility of the affected joints
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- A distinct feeling of well-being

The arthritic is enabled to increase his daily activities or to better withstand the surgical procedures of orthopedic restoration.

Laboratory studies over a five year period prove that Ertron—Steroid Complex, Whittier—contains a number of hitherto unrecognized components which are members of the steroid group. The isolation and identification of these substances in pure form establish the chemical uniqueness and steroid complex characteristics of Ertron. Each capsule of Ertron contains 5 milligrams of activation-products, biologically standardized to an antirachitic activity of fifty thousand U.S.P. Units.

Physician control of the arthritic patient is essential for optimum results. Ertron is available only upon the prescription of a physician.

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as now provided. Great as is the charity of the medical profession, there are undoubtedly cases in which those unable to pay for medical care fail to get it. There is, in some localities, a serious lack of doctors and of hospital facilities. A large number of people in the middle class group who can pay the total cost of necessary health service if it is spread over the years find themselves unable to finance an exceptional illness. But these gaps do not justify the nationalization of all medical service.

Providing medical care for the poor is not an insurance problem. We have always recognized the obligation of Government to provide free medical care to those unable to pay for it. It is true, however, that the work is not systematically organized by all states and local governments and that a more complete system could be stimulated by Federal aid.

The lack of facilities and of doctors would not be directly affected by compulsory sickness insurance. It would be more adequately taken care of by Federal aid in the construction of hospitals and in the subsidizing of doctors where medical practice will not provide a decent livelihood.

The need for insurance for middle income groups has not been adequately met, but doctors in many states are now making promising experiments in voluntary health insurance. It is the obligation of the profession to see that these endeavors continue. I do not think it is the function of Government to compel men to insure themselves against a possible uneven burden of illness, but I do think that such insurance should be available to those who desire it.

Correcting deficiencies in medical service today is entirely feasible without nationalizing the entire medical profession. The Wagner-Murray-Dingell bill is not an effort in good faith to make our medical service better, but an effort to stop the present system and to control all medicine and all doctors from Washington.

Senator Pepper has also made proposals regarding medical care. His so-called "Super EMIC Bill," without a payroll tax, offers free medical care to mothers and to all citizens under twenty-one years of age. This bill does not even purport to be an insurance measure. It simply proposes that the Government, at the expense of the taxpayer, provide nearly half of all

for Minimum Trauma in Hormone Injections

For minimum irritation and seepage from intramuscular hormone injections, thousands of physicians choose bright razor-sharp Vim needles. Vim points are hollow-ground with keen cutting edges that gently slit rather than puncture the tissues. Most important, physicians find that Vim needles hold their sharpness despite continued use and sterilization.

There are two excellent reasons why Vim stays sharp longer. Vim is the needle made from Firth-Brearley Stainless Cutlery Steel, the "sterling of stainless steels", which has been *heat-treated* and *uniformly tempered* to exactly the hardness demanded in a *cutting* instrument.

The following lengths and gauges for intramuscular work fit any standard luer syringe and may be ordered from your surgical instrument dealer:

20 gauge, in lengths 1″, 1¼″, 1½″, 2″, 4″
21 gauge, in lengths 1″, 1¼″, 1½″, 3″
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If you have been troubled with dull needle points, use Vim needles. They serve equally well for general Hypo, Intravenous, Intramuscular, Intradermal, and Subcutaneous work. Write us for a complete list of Vim sizes and points suited to your specialty.

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CUTLERY STEEL HYPO NEEDLES

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the medical service required by the people of this country. At least it is a franker acknowledgment of what the left-wingers are trying to do than are the so-called "insurance" proposals. Senator Pepper admits that it would ultimately cost $2 billion a year. This is in line with the estimate that free medical service for the entire nation on an insurance basis would cost from four to five billion dollars a year.

In 1945 I helped work out the so-called hospital construction bill. It is based on the principle that the Government is interested in seeing that hospital service is available throughout the country up to a certain standard of beds per thousand population. Federal aid would be made available up to one-third of the total expense only if the state submitted a comprehensive plan for state-wide hospital service. Such a plan would have to include all the private hospitals, since our hospital service is built up so largely on a private basis. Administration and construction of the hospitals would be left entirely under the supervision of the state. The bill was written to avoid wide discretion on the part of the Surgeon General or of any other Federal officer or board.

While I believe strongly in Federal assistance to social welfare, I consider state and local administration essential. To insure this in any legislative measure drawn up, the standards should be stated in unmistakable terms and not left to

"BUT DOCTOR, HOPKINS HAS MADE FIVE TRIES AND IT ALWAYS COMES OUT A TOM AND JERRY!"

the discretion of a Federal officer or board. Moreover, the assistance provided should be given only to those who need it, and in a reasonable, minimum amount.

Those who do not work can be helped only out of the earnings of those who do work. The burden on the workers through taxation must not be such as to discourage increased effort and production. Furthermore, the man who is helped by the state must not be quite so well off as the man who earns his own living and stands on his own feet.

This past spring I introduced a bill for general medical assistance, following the principles of the hospital construction bill. I was joined by Senator Ball of Minnesota and Senator Smith of New Jersey. Our bill, which we intend to re-introduce in January, proposes further aid to states for general medical care at the rate of $200 million a year. The distribution is to be contingent on the state's setting up a plan by which medical care may be available to every person who is unable to pay for it. Medical care under this plan may be provided either directly by the state or local government or by private institutions paid by the state. Or the state may employ voluntary health insurance funds to look after those unable to pay for such insurance. Our proposal also would furnish increased funds to help states to expand their public health work and their medical research.

The Taft-Ball-Smith bill has been attacked by the Wagner-Murray-Dingell propagandists on the ground that it would require a means test—pictured as a horrible indignity. It is quite true that it proposes to furnish aid to only about 20 per cent of the population instead of to 95 per cent as under the Wagner-Murray-Dingell bill. That is one of the two essential differences, and a vital one.

With due respect to all concerned, the excitement about a means test is only a red herring. Every hospital today imposes a means test and asks those who can pay to do so. In our public housing program we check the income of every person before public housing can be available to him. In the District of Columbia and elsewhere, dental service is furnished free only if the principal certifies that the child or his parent is unable to pay. And there are many other examples. In my opinion, the only justification for a free service at the expense of the taxpayer is the inability of the recipient to pay for it. The amount of his income in these days of income deductions and social security is usually a definite, ascertainable figure. In millions of cases today, the means test is administered in an unobjectionable way.

The fundamental issue is whether the Government shall look after the indigent or whether it shall look after the entire population. The first principle has always been embodied in the law of every free Anglo-Saxon people; the second is socialism.

State care of the 20 per cent having the lowest income is no interference with the freedom of the other 80 per cent. Nor does it interfere with the freedom of the medical profession. The real opposition to our bill is that it does

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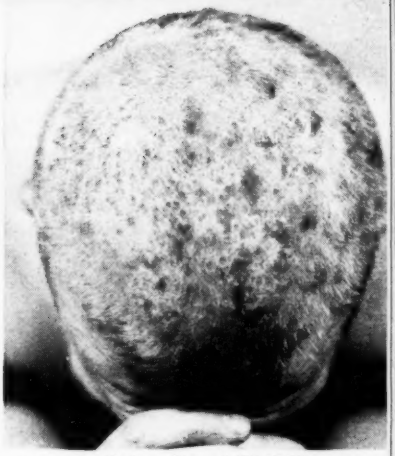

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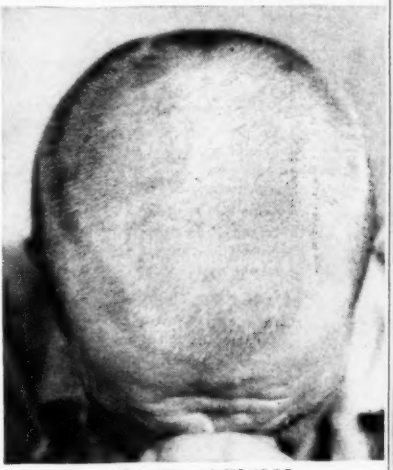

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not socialize medicine and does not take away the health function from state and local government.

Undoubtedly, any Federal aid presents the danger of Federal domination. But our bill provides safeguards against interference with state and local independence by those who administer the new assistance. Most New Deal measures are so drafted that Federal officers have wide discretion. By using it arbitrarily, some agencies—*e.g.*, the United States Employment Service and the Children's Bureau—have directed state and local officials in the details of how their offices must be run. Yet bills need not be drafted in that way. I believe that Federal aid can be furnished without Federal control if someone who desires to preserve state and local independence instead of desiring to destroy it drafts the legislation.

The problem discussed here is partly a medical one but, above all, a governmental one. I hope the medical profession will take an active and continued interest in it. If physicians assume the position that everything is rosy and that nothing need be done, they are likely to be swamped politically by the demand for improved medical service. I have felt that the attitude of some medical associations is almost completely negative. It is up to the doctors to recognize that there is a problem and to take an active part in working out the solution.

The bill which we have presented is not perfect. Every word should be examined and considered. But if medical men do take an active part, they will have the enthusiastic cooperation of that large majority of Congress that fears more than anything else the increased concentration of power in the hands of Federal bureaus. It is up to us to show that a Government based on liberty of the individual, of the professions, and of local communities can assure better social service than the most efficient socialistic state. —ROBERT A. TAFT

Short Stopper

When my husband and an associate opened their office, they hired a colored maid to tidy the place and were well pleased with the results. One day Dr. Finch met their maid as he approached the office building. He noticed that her usual trim uniform had been replaced by a garish blue garment. She stepped in front of the doctor and coyly asked, "Doctor, how do you all like my new uniform?"

Across her ample shoulders, in painstakingly embroidered lettering, was this caption: "Smith and Finch, M.D., F.A.C.S., Medicine & Surgery, 205 South 4th Street." —ZELLA C. FINCH

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1. W. B. Saunders Company, Philadelphia, 1942
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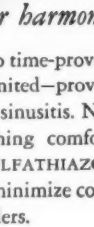

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Tax Court Rule Affects Lump-Sum Receipts

When an account of several years' standing is finally settled by a lump-sum payment (as occasionally happens), the physician, until now, has been obliged to report it as current income in filing his tax return. As a result, the taxpayer has sometimes been edged into a higher surtax bracket. Moreover, the settlement itself has been subject in recent years to a higher rate than had it been reportable in the period when the medical services were rendered.

Back in 1939, the internal revenue code was amended to take care of similar situations in the case of wage earners. It was recognized that persons who work for long periods before receiving their full compensation may undergo a certain tax hardship, and provision was made for pro-rating current income to the years in which it was earned.

The provision, however, did not appear to cover physicians. With no case on record as a precedent, the practitioner had no alternative but to pay the seemingly unjustified tax.

A few weeks ago, the Tax Court provided the needed precedent in ruling on a claim entered by Dr. Jerome Nast of Corpus Christi, Texas; and though Dr. Nast's particular claim was disallowed, the code was so clarified that other M.D.'s may now—under specific conditions—take advantage of its provisions.

In effect the code states that income received in a taxable year for services rendered during a period of thirty-six (or more) calendar months may be apportioned to the months it rightly covers and taxed accordingly—provided that the amount received in the taxable year is equal to at least 80 per cent of the total bills rendered during the period of treatment.

For example, if a payment of $800 has been received during 1946 for the treatment of a chronic condition that required $1,000 worth of services between Jan. 1, 1940 and Jan. 1, 1943 (thirty-six months), the physician may reduce his income tax this year by pro-rating the $800 settlement to the months it properly covered. It should be noted, however, that all payments made on account since the first visit in 1940 would have to be taken into consideration; a lump-sum settlement may not be pro-rated unless it covers at least 80 per cent of the entire bill.

Dr. Nast lost his claim because of this 80 per cent provision. His patient, under treatment from July 1, 1934 to Sept. 4, 1943, had run up a total bill of $3,096, but his lump-sum settlement of the unpaid amount, $1,946, was far below the required 80 per cent to permit pro-rata computation of the doctor's income tax. —ROBERT S. HOLZMAN

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*Healy, J. C.: Hypochromic Anemia, Treatment with Molybdenum-Iron Complex, Journal-Lancet *66*:218 (July) 1946.

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Contains elements essential to rapid rebuilding of the convalescent, in a delightful wine-flavored base. Provides a desirable multiple stimulation to recovery, in convalescence, anemia, and other debilitated states, by supplying:

❶ **B COMPLEX**—high potencies of the established B vitamins, plus the whole B complex from liver, rice bran and hydrolyzed yeast;

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❸ **AMINO ACIDS**—15% enzymatic yeast hydrolysate containing supplemental amounts of the 10 essential amino acids, plus other amino acids and polypeptides . . . for readily available *extra* nitrogen and stimulation of vitamin assimilation and hemoglobin formation.[1,2]

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Protein hydrolysate (45% amino acids)	6.75 Gm.
Thiamine hydrochloride	3.0 mg.
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Niacinamide	15.0 mg.
Pyridoxine	1.0 mg.
Peptonized Iron, N. F.	0.4 Gm.
Liver, B complex fraction	0.5 Gm.
Rice bran extract	0.5 Gm.

DOSAGE—15 cc. (approximately 1 tablespoonful) three times daily, preferably with or before meals. Children proportionately less. Larger amounts in pronounced deficiency states.

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1. Jacobson, M.: Preliminary report on the combined effects of vitamin B complex with amino acids, N. Y. State J. Med. 45:2079-2080 (1945).

2. Ruskin, S. L.: The role of the coenzymes of the B complex vitamins and amino acids in muscle metabolism and balanced nutrition, Am. J. Digest Dis. 13:110-122 (1946).

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Tax Savings Through Security Sales

How legitimate use of law governing capital gains taxes can reduce your 1946 tax bill

Here is an explanation of how you can achieve some tax savings in 1946 if you act before the end of this year:

The current tax law divides capital gains and losses on the sale or exchange of securities into two categories. One is the short-term capital gain or loss derived from the sale or exchange of securities owned for six months or less. The second is the long-termed capital gain or loss on securities held for more than six months.

Normal income and surtax rates apply to short-term gains.

On long-term gains, if your net income exceeds $16,000, the maximum tax rate is limited to 50 per cent of one-half of the total gain. In effect, this puts the maximum tax at 25 per cent. Here is how it works:

If you receive a profit of $10,000 from the sale of securities you have held for more than six months, your tax will be 50 per cent of $5,000, or $2,500, which is 25 per cent of your total gain.

The law permits you to compute your tax on long-term capital gains in one of two ways, and you may use whichever method results in the smaller payment. One is the method illustrated above, in which you simply add 25 per cent of your long-term capital gain to the tax on your regular income. The other is to lump 50 per cent of your long-term capital gain with your regular income, and to pay the ordinary tax on the total.

The following example illustrates the importance of trying both methods of computation:

Dr. A, who has had a good year in 1946, has netted $20,000, and in addition has gained $10,000 on the sale of securities he has owned for more than six months. If he treats half of his capital gain as ordinary income—bringing the total to $25,000—his tax bill will be $9,642. Under the other method, the tax on his ordinary income will be $6,897, and this plus the $2,500 tax on his long-term capital gain will make a total of $9,397, a saving of $245.

Examine your holdings to ascertain what sales you can make this year that will deflate your tax bill. Needless to say, do not dispose of securities as a tax-saving measure if this will unbalance your holdings. There is no point in sacrificing a sound portfolio for tax savings.

A doctor who sells securities for tax purposes should carefully list his transactions by security number and date.

All such transactions must be *completed* on or before the last day of the year. —A. G. ROSS

How Do You Pronounce It?

Your technical vocabulary may be taking a tongue-lashing. Try this test!

By the time most budding physicians leave medical school, they have stored up a fund of some 50,000 technical terms. Few practitioners disagree on the meanings of those terms. But when it comes to pronouncing them, they are likely to be 100 per cent individualists.

Inconsistency is well typified by the ways in which *gynecology* is pronounced. It is derived from the Greek word for "woman," but it is mispronounced variously as

jigh nuh KAHL uh ji
jeen uh KAHL uh ji
jin uh KAHL uh ji

Inspection of the root immediately reveals the correct way to pronounce it:

gighn i KAHL uh ji

Words such as *penicillin, diabetes, diphtheria, glaucoma, infantile paralysis, long-lived, tic douloureux,* and *larynx* are not unusual. But they are widely mispronounced on both sides of the physician's desk.

The reasons for disparate pronunciations are plain. Of seventy-five medical schools that have been approved by the American Medical Association, not one lists any course work in pronunciation. The standard medical dictionaries, excellent in matters of definition, give little space in the word lists to anything but syllabification and accent.

Of four principal dictionaries, not one indicates the most frequently used sound in American speech, the indeterminate vowel as found in the last syllable of *potion, plasma, bacillus,* and *pharmaceutical.* Dictionaries normally represent *streptococcic,* for example, only as "streptococ-cic." It is impossible to determine what differences exist between the two *o* symbols and all the *c* symbols.

Another reason for differences in pronunciation is the feeling that it is not very important. This is illogical, for good speech and accurate pronunciation are invaluable tools in medical practice.

Largely by the way you say words do you establish rapport—or fail to

---

▶ James F. Bender, Ph.D., author of this article, is director of the National Institute for Human Relations. He has written the "NBC Handbook of Pronunciation," "Salesmen's Errors of Grammar," and "Four Vocabulary Tests." He has been called upon by a number of pharmaceutical houses to train detail men in the correct pronunciation of medical terms.

establish it—with your patients. Your 50,000 terms are used for scientific accuracy. Whereas your patients use *head*, for example, with a baker's dozen of meanings, you are meticulous in the use of indices such as *cerebro-*, *caput-*, and *cranio-*. It makes sense to use similar care in pronouncing a word.

Most technical terms, even those added each year, are of Greek and Latin origin. By referring back to the dead languages, it's possible to make your medical pronunciation both orthodox and accurate. Try the quiz below. It's the first of four prepared for this magazine.

—JAMES F. BENDER, PH.D.

PRONUNCIATION QUIZ

Which way do *you* pronounce these commonly used medical terms? Take your pick—then turn to page 116 and compare your choice with the orthodox pronunciation, based on the Latin or Greek root of the word. Capitalized syllables show primary accent, italicized syllables show secondary accent.

	A	B
1. anesthesia	*an* uhs THEE zi uh	*an* uhs THEE shuh
2. cerebral	suh REE br'l	SEHR uh br'l
3. eczema	EK si muh	EG zeem uh
4. psoriasis	suh RIGH uh sis	soh ri AS is
5. meningitis	*men* in JIGH tis	*men* in JEE tis
6. dengue	DENG gay	DENG gi
7. eustachian	yoo STAYK i 'n	yoo STAYSH i 'n
8. endocrine	EN doh krighn	EN duh krin
9. abdomen	ab DOH m'n	AB duh m'n
10. riboflavin	*righ* bo FLAY vin	*ree* bo FLAV 'n
11. duodenum	doo AHD n'm	*doo* oh DEE n'm
12. coital	koh EE t'l	KOH i t'l
13. echolalia	*ek* oh LAY li uh	*ek* oh LAL i uh
14. ptomaine	toh MAYN	TOH may een
15. digitalis	*dig* i TAL is	*dij* i TAY lis
16. epizootic	*ep* i zoh AH tik	ep i ZOO tik
17. pineal	PIN i 'l	pi NEE 'l
18. psychiatry	sigh KIGH uh tri	suh KIGH uh tri
19. laryngeal	luh RIN ji 'l	*la* rin JEE 'l
20. rale	rayl	rahl
21. streptococcic	*strep* tuh KHAK sik	*strep* tuh KHAK ik
22. gnathalgia	nath AL ji uh	*navth* al JEE uh
23. oocyesis	oh oh sigh EE sis	oo SIGH uh sis
24. syzygy	SIZ i jee	SIGH zi gi
25. meatus	mee AY t's	MEE t's

(System of notation used by permission of Sales Training Publishing Co., Roslyn Heights, N.Y., publishers of Salesman's Mispronunciations.)

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*Goodman, L. and Gilman, A. The Pharmacological Basis of Therapeutics, 1941, p. 460.

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			Number	Percent
URTICARIA	Acute	63	60	95
	Chronic	71	50	70
	Total	134	110	82

		Number of Cases	Improved	
			Number	Percent
SEASONAL ALLERGIC RHINITIS (Grasses and Ragweed)	No previous therapy	81	69	85
	Following other unsuccessful therapy	59	50	84
	Total	140	119	85

		No. of Cases	Improved (Rhinitis)		Improved (Asthma)	
			Number	Percent	Number	Percent
SEASONAL BRONCHIAL ASTHMA (Grasses and Ragweed)	Asthma with allergic rhinitis	24	19	79.2	11	46
	Asthma alone	6			3	50
	Total	30	19	79.2	14	46

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Sound-Conditioning Your Office

Two methods you can use as a means of reducing noise levels

Many a physician who consciously cocks an ear at his office sound effects finds that they don't produce the pleasantly subdued tone that he imagined. An infant's wail, a too-audible consultation, a medley of laboratory noises can be reminders that your office needs sound-conditioning.

Applied to a medical office, the science of sound control breaks down into two simple remedies: You can set up sound barriers which prevent irritating noises from filtering all through your suite. Or you can cut down noise at its source through the principle of sound absorption.

The first course—that of sound isolation—may, in some cases be followed by the physician with little outside assistance. What should you do, for instance, when it's obvious that your "inner sanctum" questions and answers are seeping through to patients waiting in the reception room? First, like the ship's carpenter, look for leaks. It's likely that the sound is escaping through poorly fitted doors, transoms, or lightly constructed partitions. If the trouble is obvious, a carpenter can be instructed to make the necessary corrections.

Sound-conditioning based on this barrier principle needs special attention when you build or remodel an office. For maintaining a pleasant and subdued atmosphere, it's well to employ such factors as:

Hallways or closets between adjoining rooms.

Plastered stud or masonry walls between rooms (six-inch lightweight concrete block is preferable).

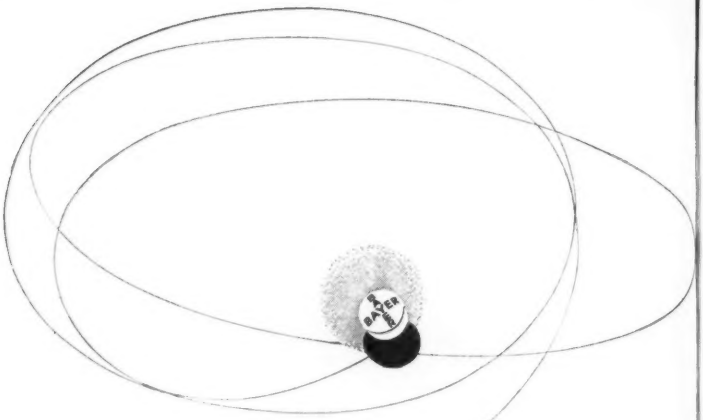
Heavy doors and windows, carefully fitted and sealed.

The second principle of sound control concerns itself with sound absorption—the reduction of noise within a room. You've undoubtedly noticed the acoustical reverberations of your voice and footsteps within an empty house. Had there been rugs and upholstered furniture, they would have absorbed much of the noise. That same principle can help in your office; but acoustical scientists have developed special sound-absorbent materials which go still further toward noise elimination.

Below is a check-list of standard methods you can use to help reduce noise at its source:

Elimination of such noise-makers as rattling windows, squeaky doors and floors, noisy shutters, jangling phones and door-bells.

Addition of heavy carpets or rugs, placed over fairly thick felt



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pads; rubber tile flooring.

Use of upholstered furniture, drapes, fabric wall hangings, and other sound-absorbent materials.

Covering ceilings and walls with acoustical tile, wallboard, or plaster.

In many instances, a ceiling covered with acoustical material will suffice to cut down ordinary room noises. Greater sound control is provided when the walls also are covered. However, this is a matter for an acoustical engineer to decide, for it depends largely on the size of the room and on the amount of natural absorption in furniture and fittings.

Acoustical tile, panels, and plaster are manufactured in an assortment of forms, varying in shape, thickness, and material, each designed for a specific application. Most common is the perforated acoustical tile. Price depends on whether the materials must be incombustible and what structural requirements they must meet. The average expense of treating large offices runs from thirty to fifty cents per square foot. An acoustical contractor can do the work, particularly if it's only a ceiling job, during your out-of-office hours or at night.

Many acoustical materials can be painted to conform to the decorative scheme of the room in which they are used. They offer no special maintenance problem and to some degree they also serve as heat insulators.

Acoustical contractors are willing to give an analysis of existing buildings or to assist architects in preparing specifications for new buildings. National acoustical manufacturers such as the Johns-Manville Corp., the Celotex Corp., the United States Gypsum Co., and the Armstrong Cork Co., have representatives in most communities.

—JOHN G. SHEA

Sidelights

[*Continued from page* 40]

We recently received this jaundiced memorandum from our Connecticut correspondent:

"Re: 'Doctor Rindge Day' in Madison, Conn . . . I should think doctors generally would be getting a little fed up with the frills these Doctors' Days involve. Isn't there some venerable physician who has refused to stand in the sun while 100 droopy, drippy moppets march past, tagged 'I am a McBlight Baby'? Hasn't any rough-hewn country practitioner balked at lapping pink punch while a lady poetess reads ten stanzas of pure Karo?

"Dr. Arthur E. Hertzler, Kansas' sharp-tongued 'horse-and-buggy doctor' who died recently, would have had the *mot juste* for an overdone ceremony. Dr. Hertzler used to turn to his host at evening's end, say, 'Blah, Blah, Blah,' and depart. He explained that it saved him the work of saying he'd had a fine time, an excellent dinner, and hoped to come again.

"More doctors probably feel like Hertzler than we know about. I'll bet Doctor Rindge has an almost irresistable longing to smack the drum majorette on the same spot he whacked her when he had her hanging by the ankles eighteen years ago."

Detroit's Wayne County Medical Society announced a glittering series of talks, panel discussions, lectures, joint meetings, and banquets to take place between Oct. 7 and Dec. 2, 1946. Besides a galaxy of speakers on socialized medicine, including senators, surgeons general from nineteen countries, representatives, former ambassadors, generals, and admirals, the series includes all manner of scientific bigwigs from Frank Lahey down. This Thanksgiving dinner of scientific goodies is topped off, appropriately enough, with a symposium on "Dizziness."

ANSWERS TO PRONUNCIATION QUIZ

(see page 109)

1–A; 2–B; 3–A; 4–A; 5–A; 6–A; 7–A; 8–A; 9–A; 10–A; 11–B; 12–B; 13–A; 14–A; 15–B; 16–A; 17–A; 18–A; 19–A; 20–B; 21–A; 22–A; 23–A; 24–A; 25–A.

The improved Oravax now provides a wider measure of protection against the secondary invaders following the cold virus.

Each small enteric-coated tablet now contains 60 billion killed organisms and the soluble (ecto-) antigens from 8,625 million:

D. pneumoniae, Types I, II, III, VII and VIII, (each)	5,000 million
and the soluble antigens from (each)	750 million
Streptococcus hemolyticus, Type A	10,000 million
and the soluble antigens from	1,500 million
Streptococcus viridans	5,000 million
and the soluble antigens from	750 million
H. influenzae, Type a	2,500 million
and the soluble antigens from	375 million
K. pneumoniae, Type A	5,000 million
and the soluble antigens from	750 million
Staphylococcus aureus and albus, (each)	5,000 million
and the soluble antigens from (each)	750 million
N. catarrhalis (no soluble antigens)	2,500 million

Much has been written in the medical literature—both pro and con—concerning the value of oral bacterial vaccines. However, the published reports of a number of clinicians indicate that Oravax will build a measure of protection in a high percentage of cases against secondary invasion by organisms included in the formula. For this reason, Oravax is widely prescribed to aid in reducing the severity and duration of secondary infections following the cold virus.

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for example, now offer relatively complete coverage. Others (such as Pennsylvania's) offer surgical and medical care in the hospital.

¶ How to extend coverage to the indigent, medically indigent, chronically ill, and over-aged. The most frequently suggested solution follows the veterans' home-town care outline.

¶ How to increase reciprocity. With the present wide variation among plans, it is difficult to sell employe-enrollment to companies that maintain personnel in many states. As many plan managers point out, enrollment of large groups is the most direct method of building subscriber-volume, and "high volume is the strongest answer to Federal insurance proponents."

¶ How to organize and staff AMCP's new central office in Chicago for the multiple jobs it must do. Besides gathering, correlating, and disseminating statistics on enrollment (now incomplete), on utilization of benefits, and on administrative costs, the AMCP headquarters staff will also spread new ideas in the fields of advertising, publicity, public relations, physician-patient relations, and the now vital area of physician-plan relations.

¶ How the relationship of AMCP with the AMA will be finally established. To AMCP, a separate organization, the AMA has given use of its printing presses without cost and has supplied legal counsel. Although AMCP must stand on its

[*Continued on page* 120]

"IT'S TOUGH GETTING BACK TO CIVILIAN PRACTICE. I WAS HEAD EXAMINER AT A WAC CAMP."

own feet after the organization period is over, it is now dependent upon the AMA for financial assistance. How much money will be lent is still being debated.

¶ How to increase the income of AMCP. Dues of the nine charter members are expected to produce only about $12,000 a year.

¶ How to increase the efforts of salesmen who handle medical and surgical policies as well as hospitalization. While employed by Blue Cross, these men receive a portion of their pay from the affiliated medical and surgical service. But at present, there is widespread complaint that these salesmen do not push surgical and medical contracts.

Although answers to these problems will not be found for many months, by the end of the year AMCP will be sufficiently organized to undertake at least experimental solution. Frank G. Smith of California Physicians Service has been tentatively named full-time director of AMCP.

On the surface, it may appear that there has been little improvement since last summer. Actually, physicians can be sure that the period of uncoordinated action is over.

—EDMUND R. BECKWITH JR.

[EDITOR'S NOTE: The following addendum was received from the author at press time.]

The issue which has blocked Associated Medical Care Plans since February has been temporarily settled but there will be more argument soon. Wisconsin Physicians Service was accepted by test-vote at the Chicago meeting of AMCP because it was demonstrated that physicians maintain control of the plan despite backing by commercial companies. Twenty-four insurance companies sell the same policy which was written by state medical society members; benefits and premiums were set by physicians; claims are settled by a ten-man reference committee of five doctors and five company representatives; and the companies have no alternative but to do business on the doctors' terms or get out.

But members of the Wisconsin delegation which gained acceptance at Chicago went home to a bitter intra-state fight with Milwaukee physicians who back that city's Surgical Care Plan. The profession got unfavorable publicity.

AMCP must now look forward to two new, major problems. If competition develops in many areas between state and county society approved plans, all physician-sponsored plans will be jeopardized. Financial failures may occur. Dissension within the profession will do much harm to the thesis that voluntary health insurance plans are primarily designed to improve medical service to the public.

It will be AMCP's task to effect compromises among plans, to head-off cut-throat competition, and to patch up factional differences among physicians.

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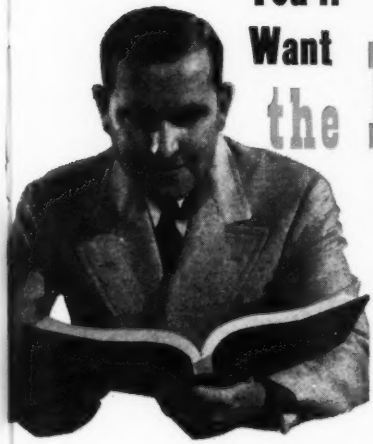

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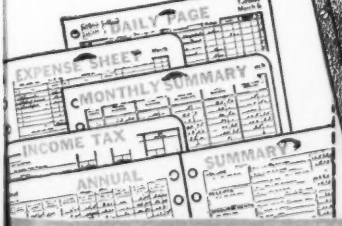

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When Can You Refuse Treatment?

Here are some suggestions on the problem's legal aspects

Sooner or later in every M.D.'s career, a case appears which makes him wonder about his obligation to treat. And at some point, there is a patient of long standing he would like to send packing.

Actually, nothing in the common law requires you to take on a new patient. It has been argued frequently that a physician is a quasi-public servant; but as long ago as 1901 it was ruled that a state's permission to practice does not require a physician to render service on any terms other than his own.

The case of Hurley vs. Eddington (Ind. 1901) involved a general practitioner who refused treatment to a dangerously ill man. Without giving any reason, and although no other patient claimed his attention at the moment, the doctor declined to visit him. The patient died and the doctor was called to court, but the case was dismissed.

Refusal of treatment when called to attend upon a public disaster or an automobile accident would obviously bring censure from both the public and one's medical society. Nevertheless, there is no requirement before the law.

Dropping an established patient is a different matter. The patient-doctor relationship is not normally considered ended until:

¶ The patient discharges the doctor, arbitrarily or not.

¶ The illness is over.

¶ The doctor and patient agree to end it.

¶ The doctor withdraws.

Once you accept a patient you can end the relationship only by giving reasonable notice of withdrawal. The fact that treatment is given gratuitously has no bearing on the matter. It has been ruled that unless doctor and patient have entered into an agreement limiting attendance to a specific period, the patient implicitly engages the physician to attend throughout the illness. Even sickness on the part of the doctor is not sufficient cause for stopping treatment abruptly. In the case of Stohlman vs. Davis (Utah, 1928), the physician became ill while his patient was still in the hospital. Without notice to the patient, he sent his son to take over. The court ruled, when the doctor was later sued, that "his physical condition did not interfere with or prohibit the giving of due and ample notice of his disability to his patient or to his patient's father. A clear duty under the circumstances was imposed upon him either to secure the patient's acceptance of the substitution of his son, Dr. Herbert Davis, or to give him notice to secure another

Handitip

Blood-Pressure Aid

When I want to get blood-pressure readings on a child, I tell him, "This is just a little test for measuring how strong your muscles are." I make it a point to avoid the words "blood" and "pressure." The youngster is relaxed and free from nervousness when the readings are made. With this formula, no child patient has yet resisted having the pressure cuff applied.

—M.D., MASSACHUSETTS

---

physician or surgeon of his own choice."

Protection from suit for negligence when a case is dropped can best be gained by a complete record of your action. The following points should be covered:

¶ Your reason for dropping the case. (No reason need be given the patient.)

¶ The date, time, and circumstances under which the patient is informed that you are going to withdraw. (It is wise to confirm this in writing.)

¶ Your recommendation — you need make none—of another doctor or of the type of doctor if a specialist is indicated.

¶ Records of all instructions given the patient for his own care. (A follow-up in writing will strengthen your defense.)

¶ Complete accounts of all visits to the patient.

What constitutes "reasonable notice" must be judged from the circumstances. In 1901, a California physician, Dr. Flood, attended a Mrs. Lathrope to deliver her child. After he ordered the nurse to place the woman in position, he inserted his instruments. Mrs. Lathrope, in fear or pain, drew back, compelling Dr. Flood to release his instruments. He remonstrated with her, finally saying, "You quit your screaming. If you don't quit, I'll quit." She did not and he left the house. It was about midnight. Her husband followed, pleading, but to no avail. Finally the doctor suggested that he get help from a nearby hospital. Although the institution was contacted and responded as quickly as possible, the baby lived only eight minutes.

The court found no negligence on the doctor's part until the time he left the home. However, recovery against him was granted on the basis of abandonment during "woman's martyrdom." Said the court: "Such conduct evidenced a wanton disregard, not only of professional ethics, but of the terms of his actual contract."

Even under less stringent circumstances, due warning may imply considerable time. The availability of other doctors of equal ability and experience and the urgency of the case are both factors to be considered.

—EMILE ROLAND

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PLUS B COMPLEX

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B_2 (riboflavin) . . . . . 4 milligrams
PP (niacin and niacin amide) 30 milligrams
B_6 (pyridoxin) . . . . . 0.2 milligram
Calcium Pantothenate . . . 5 milligrams

and other members of the B complex from natural sources—yeast concentrate and liver concentrate.

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WITH THE YEARS

The many somatic and emotional changes encountered in senescence are manifested in a variety of ways, especially by a decrease in appetite. Reduced energy expenditure, atrophic gastric changes, exaggerated food dislikes, and food intolerance all contribute, and not infrequently lead to a state of undernutrition. In older patients, this chain of events can easily produce excessive weakness and impaired stamina, adding to the burdens of senility. Ovaltine proves an excellent means of preventing these complications. Its wealth of essential nutrients, as indicated by the table of composition, aids in preventing malnutrition. Made with milk as directed, Ovaltine is a delicious food drink. Older patients enjoy it as a mealtime and between-meal beverage, and especially as a bedtime drink. Its low curd tension assures easy digestibility and rapid gastric emptying, hence appetite is not impaired.

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CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

Snap It Yourself!

Simple equipment and proper film are the keys to good clinical pictures

Any physician can do his own clinical photography. Though specially designed equipment is an asset in many cases, the old family box camera will produce valuable results.* You'll find that these accessories will get you started: a portrait attachment lens, a peanut flash bulb adapter, a goose-neck examining lamp, an eight-bulb carton of G-E #5 Synchro-Press flash lamps, and a roll of Verichrome film.

Your aim-it-and-squeeze technique will have to be tailored slightly for clinical work. Time or bulb exposures should be used, with the camera resting on a sturdy table's edge. Don't depend on the viewfinder at short range; line up the lens itself with the subject.

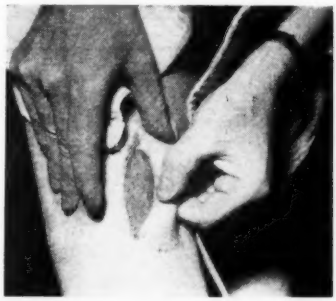
Two factors worth your close scrutiny are proper selection of film and correct use of light.

For practical clinical work, film may be classified into three general categories – color, orthochromatic, and panchromatic–plus one subdivision, line copy.

In the not too distant future, color will largely eliminate present-day black and white film. Even now, home processing units of color can be found on the market in limited quantities. Though it's expensive to buy, often inconvenient to use, color film offers many advantages for the physician-photographer in surgery, in some forms of dermatology, and in photomicrography.

Orthochromatic film is generally used for portrait work because it is capable of reproducing skin tones so well. It is blind to red and photographs that color darker than normal. A red, or even pink, lesion will show remarkably well when photographed with this film. Low-contrast orthochromatic film is also very useful in copying X-rays. Good tonal gradations are often necessary in such work, especially when dealing with the thoracic area and with inconspicuous fractures.

Panchromatic is an all-purpose



A tubular graft in sharp detail, photographed with a simple box-type camera.

*See "How You Can Use Photography to Advantage in Daily Practice," MEDICAL ECONOMICS, Sept. 1946.

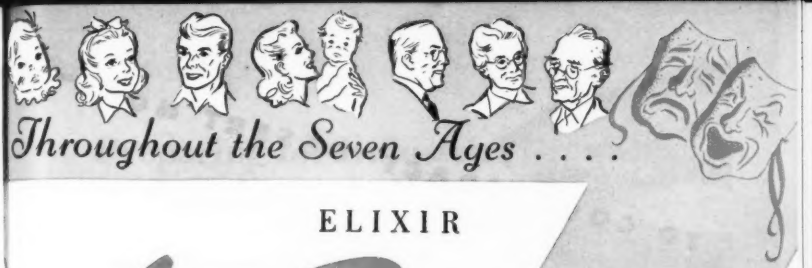
medium, fast, and ultra-fast speeds, and with coarse or fine grain. It is more color-balanced than orthochromatic, and although blue and green photograph slightly off tone, the difference is negligible.

Fast panchromatic film produces excellent results in surgery, especially when used in conjunction with a flash gun. At close range, the speed of the film allows the use of a small aperture to increase the depth of the field of focus. Even fine-grain panchromatic, which is generally a good deal slower, can be used with a comparatively small aperture. If this film is processed properly, good contrasts along with excellent tones may be secured. It is useful for photomicrography, preoperative and postoperative photography.

Line copy film produces only black and white tones with no intermediate grays. It may be purchased in either orthochromatic or panchromatic types, and is utilized for reproducing charts, tables, graphs, printed and typewritten matter, and certain varieties of drawings. It is extremely useful when such material is desired on glass slides for lecture work. The exposure of this film must be accurate in order to produce good work.

Sticking to one film is a wise rule for beginners. But once you've gained momentum in clinical photography, this principle becomes detrimental to good pictures. Later on, you may want a camera that can take cut film. Changes from black-and-white to color can be made expeditiously, and there's no waiting to finish out the roll.

An often-neglected factor—illumination—should be to the photophysician what the chisel is to the sculptor. "Mold your subject with light" is a familiar tenet among photographers; it means nothing more than creating a third-dimensional effect. Many defects—a deep cicatrix, for example—can be shown to advantage when illuminated from a 45-degree angle, but appear flat and washed out under head-on lighting. An enlarged thyroid can look non-existent with poor illumination, but greatly enlarged if lighted from the side. "Molding" can be accomplished while using either photoflash or photoflood illumination. —JAMES T. BARBASH



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XUM

Preparing for Industrial Practice

On-the-job apprenticeships help to counteract the lack of medical school courses

Although specialized training is now considered a "must" for a career in industrial practice, such training is not always easy to obtain. Only a limited number of medical schools include the subject, as such, in their curricula. Even in these, the program is generally of the short, intensive variety, and sometimes admittedly experimental in character. Consequently, the young industrial practitioner-to-be is faced with something of a challenge in educating himself for the better-paying jobs.

In lieu of formal residencies, the field offers plenty of opportunity for on-the-job training. Consider, for example, the policy of the Consolidated Edison Company of New York. Says Medical Director John J. Wittmer: "We are constantly teaching by plant symposium and conference. We train our M.D.'s to treat skin allergies, ventilation, respiratory problems, and so on. We put more stock in such training than we do in regular academic courses. True, we prefer to take on doctors who have had some specialized training in toxicology; but if a man lacks such training yet can fulfill all other requirements, we give him time for a formal medical school course in the subject. In our apprenticeship system, doctors working under the supervision of experienced men learn how to handle all manner of occupational ailments and hazards peculiar to our field."

The American Telephone & Telegraph Company is another concern that places its newcomer-physicians under experienced men for on-the-job training. More and more companies are adopting this practice. "Most plants," says the medical director of one such concern, "have had to develop their own specialized training plans because available courses are so limited."

To supplement on-the-job training, industrial practitioners in county and state medical societies have, through their special membership sections, organized clinical discussions, regional conventions, and formal post-graduate courses. One of the most noteworthy post-graduate courses put on in recent times was an eight-

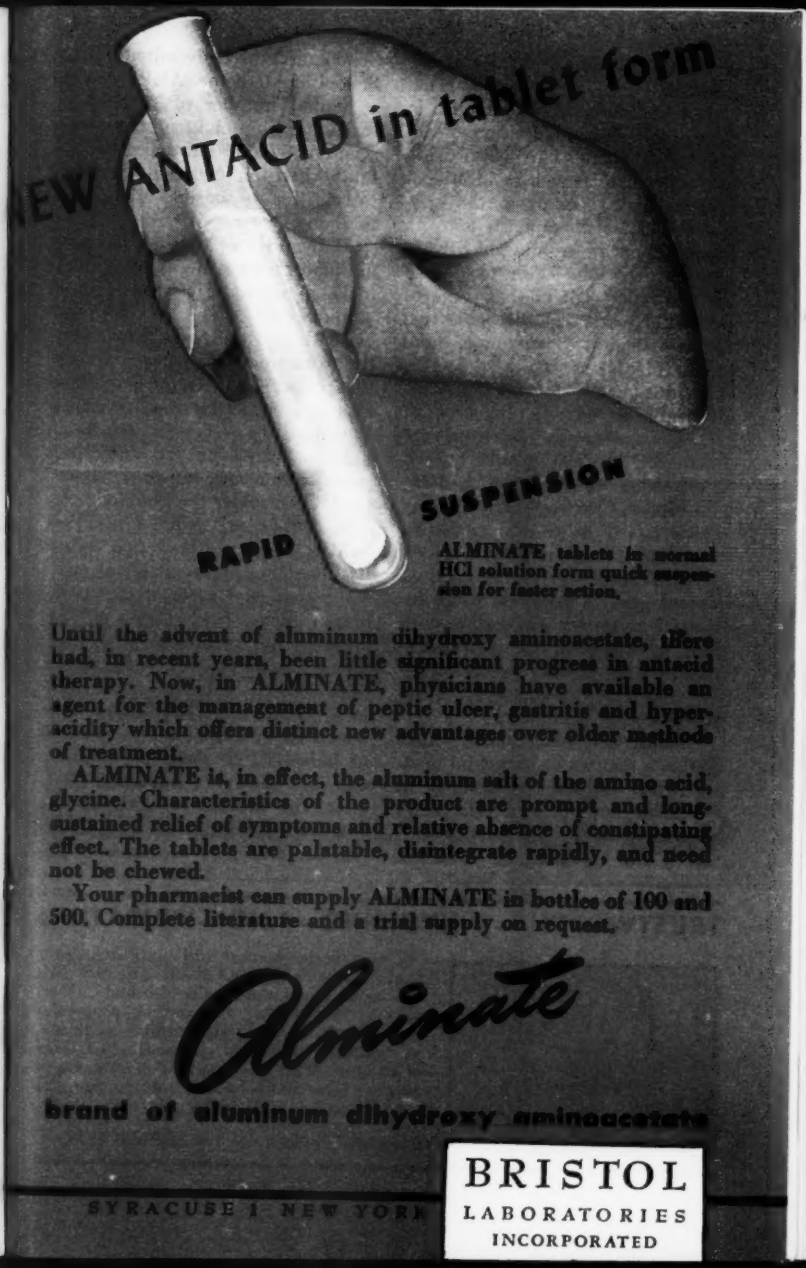
▶ This is the last in a series of articles on industrial medicine which has described in detail specific aspects of plant practice, salaries, job-hunting, ethics, employer relations and other career factors.

week series held in 1943 under the joint auspices of the Philadelphia County Medical Society and the Medical Society of the State of Pennsylvania.

Foremost among the schools which have placed special emphasis upon post-graduate work in industrial medicine are Wayne University's School of Occupational Health in Detroit and Long Island College of Medicine in Brooklyn. Now in progress at Wayne is an intensive fifteen-week orientation course, which Dr. Raymond Hussey, dean of the school, describes as "the testing out of a pattern" for post-graduate training in industrial medicine. "It is entirely experimental from the educational standpoint," adds Dr. Hussey, "and a statement of comments and criticisms from students of the course will be published at its conclusion." The medical facilities of various plants in the highly industrialized Detroit area have been made available to the School of Occupational Health for demonstration purposes.

At Long Island last month, plans were being readied for the institution's fifth annual post-graduate course in industrial medicine. In previous years the course has lasted two or three weeks, starting usually in mid-January. Lectures and seminars have been conducted at the medical school; clinics and demonstrations in the medical departments of cooperating industrial plants in the Long Island and Manhattan areas.

Many of the sessions have been conducted by leading plant physicians. Tuition fees have averaged $50-$75 for the full course, $25 for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Long Island plans to establish in time a full-fledged division of industrial medicine. This will provide undergraduate as well as additional post-graduate courses in the specialty. Particular emphasis is to be placed upon the training of private practitioners who wish to devote 50 to 75 per cent of their time to industrial work. Another objective of the college is to encourage more small plants to employ doctors trained specially for part-time industrial practice.

Last summer, the University of Rochester Medical School offered to physicians employed by the General Motors Corporation, a five-day review course in general medicine. Not confined to industrial medicine, the course was designed to present general medicine to an industrial group for integration with their own specialized experience. Similar courses may be given by the school next summer for other groups of this character.

Among other schools which have graduate courses in industrial medicine are Columbia's College of Physicians and Surgeons, Harvard's School of Public Health, the University of Pittsburgh Medical School, and the University of Texas School of Medicine. At Pittsburgh, a limited number of fellowships, extending from eighteen to twenty-seven months in duration, has been established for physicians qualified to train for responsible administrative jobs.

Many of the regularly listed post-graduate courses—dermatology, toxicology, traumatic surgery, for example—cover much of the specialized knowledge which industrial practitioners require. Hence, the proper selection of individual courses is sometimes an acceptable substitute for a general course in industrial medicine. A study program of this sort, however, should be devised under the guidance of a man well-versed in plant practice.

Many good textbooks on industrial medicine are available at medical school and medical society libraries. Some of the schools publish annually the lectures given in their post-graduate courses. And current papers on the subject appear regularly in the four leading journals which cover the field: the Journal of Industrial Hygiene and Toxicology, the Journal of Industrial Medicine, the Journal of Occupational Medicine (AMA), and Compensation Medicine. —NELSON ADAMS

Consultation Etiquette for G.P.'s

These tips can help friction-proof your relations with consultants

Good manners during consultation need plenty of two-way stretch. Not all the "seven sins" of consultants are on the specialist's side as implied in a MEDICAL ECONOMICS article some months ago.* From my experience I've learned that many a G.P. owes himself a brief check on his consultation etiquette.

If the patient's family asks for a consultation, there is one possible answer: "Certainly." Only wounded self-esteem can account for the hostile and insulted attitude some G.P.'s exhibit when the word "consultation" is mentioned. At that point, the practitioner has nothing to lose by graciously consenting. But he can lose a great deal by implying that he does not want to play unless he can keep the ball.

Suspicion that a consultation is simply a device for extracting another fee plagues some families. Others are under the delusion that the referring M.D. gets his cut from the specialist. It's up to the G.P. to counteract these notions by giving the family widest latitude in its choice of consultant. Many G.P.'s have found it to be smart tactics to start with "We have several good specialists in this field. Tell me whom you want and I'll call him."

This roundabout approach irks many men who want to show loyalty to their friends by calling them in consultation. It's probable that you owe more loyalty to your patients.

Fee troubles can best be adjusted by a phone conversation between the consultants. Most specialists will scale down their fees on the family doctor's assurance that the patient needs the consultation and cannot afford a full fee. The G.P. is well advised not to guess at the specialist's fee—nothing makes him less welcome in his professional group than relaying misinformation to his patient.

To get an office-to-office consultation under way, it's advisable for the G.P. to phone while the patient is in his office. Most men find it advantageous to start something like this: "I have here at my desk a Mr. Smith on whom I'd like your opinion." This warns the specialist not to ask questions which might call for answers embarrassing to the patient. At the same time, it promotes immediate decisions on details.

G.P.'s sometimes overlook two courtesies which the consultant deserves. First, let him know explicitly whether the reference is for diagnosis, advice, or treatment.

[*Continued on page* 140]

*See "Catechism for Consultants," April 1946 issue.

Suppose you're referring a patient with convulsions to a neurologist, and give no hint of whether you want advice or action. When the consultant draws his own conclusions and turns out an Rx for barbital, do you start grousing about "patient-snatchers"? It's safer to sidestep such friction-fomenters by being specific: "I'm about to start treatment for epilepsy, but I want to make sure that it isn't a brain tumor. Please send me a report as to your diagnosis. I'd appreciate your advice on treatment."

A second courtesy to the specialist is also a service to the patient: Send the consultant a written report of your preliminary findings. The saving in phone calls and working time is obvious, but often possible for a busy G.P. to overlook.

More complex than the office-to-office consultation, because its potential for ill will is greater, is the personal consultation. Patients in these cases are sicker, families more anxious. Words, even gestures, exchanged by the two consultants assume unnatural importance. The situation takes nice handling.

Within the framework of the consultation, the G.P. is host. Protocol requires that he arrive at the patient's home before the specialist. There is more than etiquette to this: the consultant cannot ethically look at the patient unless the G.P. is on hand. But some practitioners resent the dramatics of the situation—the family and their doctor tensely awaiting the appearance of the great man—as a piece of stagecraft which debases the G.P. They incline toward the second best choice: the two physicians driving to the house in company. This provides a period of privacy during which they can review the case.

Pre-examination consultation can sometimes be carried on in the presence of the patient's family, so that gaps in the record may be filled in orally. But when the physicians move into the sick room, etiquette requires that the family doctor offer to leave the specialist alone with the patient. Most consultants ask the G.P. to remain, but the choice should always be offered.

It is important that both physicians, before they emerge, decide who will speak to the family, and what he shall say. If it's not settled beforehand, results may be distressing. "What's the verdict?" asks one of the family. Each doctor opens his mouth, starts to talk, then

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hesitates and looks pleadingly at the other. Such a tableau is hardly one to inspire confidence.

The specialist is in the best position to do the talking. His aloofness from the family gives him a certain poise and objectivity. He can best answer questions about duration of hospital stay, prognosis, and advice. The family is paying for his opinion; they want their money's worth. A well-mannered specialist will frequently turn to the family doctor for verification. But the G.P. who shows signs of straining to run off with the conversation only compounds the anxiety already existing in a serious situation.

Technically, the G.P. is not guaranteeing that the specialist will be paid, but it is appropriate for him to assure that this is done. It should take priority over his own fee. The family doctor may expect to see the patient and his relatives from time to time for many years. The specialist may never see them again. The G.P. must assume, to some extent, moral sponsorship of the consultant's fee.

—HENRY A. DAVIDSON, M.D.

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Riboflavin	5 mg.	2 times	
Niacinamide	150 mg.	7½ times	
Ascorbic Acid	150 mg.	2 times	

SQUIBB Therapeutic Formula
VITAMIN CAPSULES

*Kruse, H. D.: Proc. Conf. Convalescent Care, N. Y. Acad. Med. 1940, pp. 15-36.

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

State Pays on Fee-for-Service Basis In Indigent Care Experiment

Maryland finances state-wide experimental program incorporating means test

Under a state-financed plan which began to operate last June, Maryland doctors are now treating an estimated 2,800 indigent and medically indigent persons each month.

The plan is financed on an experimental basis by legislative grants of $200,000 a year. Those eligible for benefits under it are the indigent (defined as people on relief rolls) and the medically indigent (a less definite category consisting of those unable to pay for medical care without depriving themselves or their dependents of other necessities). Eligibility of the medically indigent is determined by the county health officer. This means test has apparently proved a stumbling block, for approximately 85 per cent of those treated so far have been relief-roll patients.

Fees are uniform throughout the twenty-three participating counties. Based on the recommendations made by county advisory committees before the plan went into effect, these fees range from $2 for an office visit to $50 for major surgery. Doctors are paid by the Bureau of Medical Services which supervises the functioning of the plan. Physicians receive payment for services rendered within thirty days of first submission of bills.

State funds are allocated to counties in proportion to the number of people being assisted by the board of public welfare in each county. Consequently, the Bureau of Medical Services once considered an economy policy of pro-rating fee payments in accordance with available funds. This would have meant that if in any given month a county had only $800 for payment of medical bills which total $1,000, payment would be made to physicians at 80 cents on the dollar.

"This policy was not adopted because it was considered unsatisfactory," Dr. Dean Roberts, chief of the bureau, says, "although it represented a practical technique" for meeting the situation until appropriations could be enlarged. The Maryland State Planning Commission, in a report which led to the establishment of this indigent plan, estimated that the annual cost would be $1,373,587; but the legislature was reluctant to make so large an initial appropriation. Now Dr. Roberts says that the health department, of which the Bureau of Medical Services is a part, will "absolutely have to go to the legislature for a deficiency appropriation because money is going to run out.

[*Continued on page* 146]

"We don't believe in the 'pink pills for pale people' type of medicine. We are trying to develop really full diagnostic and treatment facilities to give the finest kind of care to indigents and medical indigents, but that takes more money than we have."

Services now vary from county to county, because each advisory committee has different ideas of what should be granted. But the main stress is on home and office treatment.

Little red-tape is involved in the administration of the Maryland plan, and a limit of $10,000 on annual administrative expenses eliminates the possibility of bureaucratic overloading. Doctors submit a single report of services rendered to a patient to the county health officer who reviews it and then forwards it for payment to the Bureau of Medical Services. If the validity of a report is questionable the health officer may seek the advice of the county advisory committee. The committee also serves as an appeal board for physicians who are dissatisfied with the payments they receive.

An indigent patient establishes his eligibility by securing a certificate signed by the executive secretary of the Public Welfare Department. A person who believes himself to be in the medically indigent category submits an application to the county health office, which determines the patient's eligibility on the basis of his income and the estimated cost of the required medical treatment. In emergency cases, the officer can authorize care before the applicant's eligibility is determined.

—C. F. LUCE

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ORETON (testosterone propionate) in oil for intramuscular injection in ampules of 1 cc. containing 5, 10 and 25 mg. in boxes of 3, 6 and 50 and in vials of 10 cc., each cc. containing 25 mg. ORETON-M Tablets (methyl testosterone) 10 mg. in boxes of 15, 30 and 100.

1. McGavack, T. H.: J. Clin. Endocrinol. 3:71, 1943.

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†*Christopher Marlowe (1564-1593)*
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ESTABLISHED 1856

The Co-op Answer to Compulsion

Plan of Elk City's Community Health Association said to outshine fee-for-service medicine

High cost and limited coverage make prepayment plans which function on a fee-for-service basis an inadequate answer to the challenge of compulsory sickness insurance. I believe that the American people's health problems can best be met through cooperative medicine predicated upon four cardinal principles: group practice, periodic prepayment, preventive medicine, and consumer participation.

Some form of security against sickness is certainly forthcoming. According to recent polls, 68 per cent of the American people believe that the Federal Government should collect enough taxes to provide needed medical care for everyone. Either the medical profession will take the initiative and inaugurate, with Government help, a system of its own, or the Government will institute a plan of sickness insurance without the help of the profession.

The problem before physicians is how to prove compulsory insurance unnecessary by making good medical and surgical care available to low-income groups.

Since 1929, I have been associated with what was originally an

► Dr. Michael A. Shadid (left), who presents here his views on cooperative medicine, has long been an outspoken critic of organized medicine. "Should we fail in our efforts to defeat the AMA medical hierarchy," he recently told physicians who had gathered to plan a national federation of health cooperatives, "I favor the conversion of this federation into an association for the advancement of state medicine in this country." While in disagreement with Dr. Shadid, the editors of MEDICAL ECONOMICS believe he has a right to be heard.

experiment in cooperative medicine. Its success has produced a promising alternative to compulsory sickness insurance. At Elk City, Okla., the Community Health Association has been established to provide medical and surgical care for low-income farmers. Today, 2,500 families are members. The association's success has been uninterrupted for the last fifteen years.

Originally, each subscriber paid $50 toward the building and equipping of a hospital. He also promised to support the medical staff according to these annual prepayment terms: one person $16; two persons $24; three persons $30; four persons $34.

These dues for medical and surgical care are enough to provide each physician on the staff with a net salary of $600 monthly. The chief of staff nets $700. In addition to this income, staff M.D.'s as a group derive 50 per cent of the fees received for examination and treatment of non-members. Once a year, each physician receives a month's vacation with pay. When ill, he receives his salary for as long as a three-month period.

Consumer control is an important element in this co-op plan. Members of the association, most of whom live within 50 miles of Elk City, meet once a year to transact society business. They elect a board of trustees which meets at least once every three months. The trustees engage the medical director, who is given authority to hire physicians and other necessary personnel. The board also employs a hospital administrator.

Although the association's members have paid but $125,000 for shares in the association, it currently has assets worth $395,000. A large part of this sum has accrued from services to non-members on a fee basis. Additions to the original hospital were built in 1934, 1936, and 1940. Its first floor now contains physicians' offices, X-ray and clinical laboratories, a physiotherapy department, a drug store, business offices, waiting rooms, and a dental department. Operating and delivery rooms, plus 100 patients' beds, occupy the second and third stories.

As far as this low-income group of farmers is concerned, compulsory health insurance could serve no useful purpose. It could more easily prove disastrous by breaking up a beneficial cooperative group. The same may be said of other groups similarly organized at Amherst, Texas; Hardtner, Kansas; Washington, D.C.; and Two Harbors, Minn.

Compulsory health insurance meets the problem of costs through tax funds. It does not improve the quality of medical care, and it makes no provision for integrating physicians and specialists to deliver group medicine. It leaves the practice of medicine where it is now—on a solo basis.

After many years of pressure, the

AMA grudgingly endorsed a form of prepayment which retains the fee system. But this system puts the plan beyond the reach of those who need it most: the low-income groups. Under the fee-for-service plan, prepayment funds are seldom sufficient to meet doctors' bills. Fees then have to be revised downward, making such plans unsatisfactory to M.D.'s as well as to the public.

Plans designed by the AMA are hedged with all sorts of "safeguards" which cut down their scope. Old people have been generally excluded as have all families whose income exceeds two or three thousand dollars a year. Most plans accept only employed persons and applications must be made by no less than 75 per cent of a group of employes in a given business.

Cooperative medicine alone is not a complete solution to the health problem. There are many people who cannot meet even the cost of cooperative medical care. Under the present competitive health system, these people are cared for in V.A. hospitals and in city and state institutions. Under a cooperative system, the indigent can be helped through Government subsidies to health cooperatives.

Certain activities which are now functions of Public Health Service must not only continue but be expanded. Equipment, facilities, and the specialized staff of a large medical institution are required to treat syphilis, tuberculosis, cancer, arthritis, epilepsy, and insanity. These diseases threaten social as well as individual welfare. Treatment is too long, too technical, or too expensive to handle through either private or cooperative enterprises.

Fee-for-service medicine is inadequate and beyond the reach of the common people. Cooperative medicine, bolstered by Government subsidies for the indigent, and by Government research in "incurable" diseases, offers the best solution to the health problems of the American people. —MICHAEL A. SHADID, M.D.

Oops, Sorry!

While having lunch one day shortly after my return from service, I recognized the man next to me at the counter as Buddy Morgan, a business man I hadn't seen in years. He was kind enough to compliment me on my service record and to ask how I was getting along. I took pains to let him know what sort of medicine I was practicing and where my office was located. Moreover, I intimated that I would see a patient most any time. I finished my verbal onslaught by handing him one of my professional cards and asking, as an afterthought, what he was doing. "Pediatrics," he answered—and through a haze of embarrassment, it occurred to me that he was not Buddy Morgan at all but a local physician I had met once before the war.

—JOHN MCCOLLOUGH, M.D.

What P. D. R

How to use each section ur

SECTION I (Pink)

(Items Listed Alphabetically)

Section I contains an alphabetical listing of pharmaceutical specialties and biologicals. Also each manufacturer's name appears alphabetically with a listing of his products. Wherever a page number appears a full description of the product will be found on the page referred to in Section IV (White).

FL-GL

FLUAGEL
Breon, George A., & Co., page 276
FOILLE
Carbisulphoil Company
FOLESTRIN
Armour Laboratories
FOLLACRO
Schieffelin & Co.
FOLLESTROL
Blue Line Chemical Company. The
FOLLUTEIN
Squibb, E. R. & Sons, page 338

FORBES LABS. PRODUCTS
Forbes Laboratories, Inc.
350 Madison Ave.
N. Y. C. 17, N. Y.
Estrogenic Substances in Sesame Oil (Forbes), page 296
Gonatrope (Forbes), page 296
H. F. (Forbes), page 296
Liver B-Complex Ferrous (Forbes), page 297
Liver Injection U.S.P. (Forbes), page 297

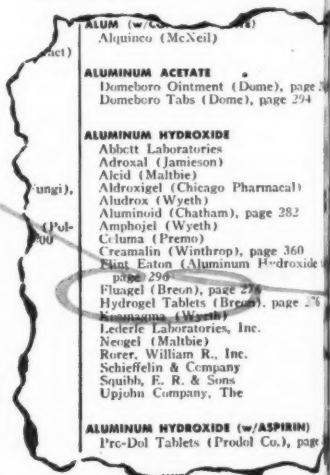
FORMA TROPIN
Abbott Laboratories
FORMAC
... Inc., The

If you remember a specialty (Fluagel, for example) but not the manufacturer's name, you would first refer to the Pink Section locating the name (Fluagel). This gives you the manufacturer's name and if a page reference follows, you will find a complete product description under the manufacturer's name in Section IV (White).

SECTION II (Yellow)

(Drug and Pharmacological Inde

This section is a classified compilati pharmaceutical specialties and biolo by drug groups and under pharmacol descriptions. Under each drug grou pears the item's name together wit manufacturer's name and if a page n is given a full description appears in Se IV (White).



ALUM (w/Co...)
Alquinco (McNeil)

ALUMINUM ACETATE
Domeboro Ointment (Dome), page 2
Domeboro Tabs (Dome), page 294

ALUMINUM HYDROXIDE
Abbott Laboratories
Adroxal (Jamieson)
Alcid (Maltbie)
Aldroxigel (Chicago Pharmacal)
Aludrox (Wyeth)
Aluminoid (Chatham), page 282
Amphojel (Wyeth)
Celuma (Premo)
Creamalin (Winthrop), page 360
Flint Eaton (Aluminum Hydroxide page 296
Fluagel (Breon), page 276
Hydrogel Tablets (Breon), page 276
Kaopagma (Wyeth)
Lederle Laboratories, Inc.
Neogel (Maltbie)
Rorer, William R., Inc.
Schieffelin & Company
Squibb, E. R. & Sons
Upjohn Company, The

ALUMINUM HYDROXIDE (w/ASPIRIN)
Pro-Dol Tablets (Prodol Co.), page

If you are interested in findi aluminum hydroxide product and y not remember the name of any pa one or the manufacturer, you would look in this section.

Copies of *P.D.R.* (Physicians' Desk Reference) are being distributed free this m to over 100,000 physicians. *P.D.R.* is not being published with any intention of fluencing in the slightest degree the therapeutic practices of any physician.

MEDICAL

RUTHERFO EW

XUM

Does For You

on ur P.D.R. most efficiently

ow) SECTION III (Blue)

Inde *(Therapeutic Indications Index)*

pilation **ll products listed in this section are** biolo **described in Section IV (White). Here** nacol **product is listed under various thera-** group **ic indication classifications designated** with **the Medical Director of each manufac-** ge **nu**. in Se

Glutasin (Mc , page 305
Valentine's Preparation Meat Extract (Valentine's), page 354

GASTRIC SUBACIDITY
Acidol Pepsin (Winthrop), page 359

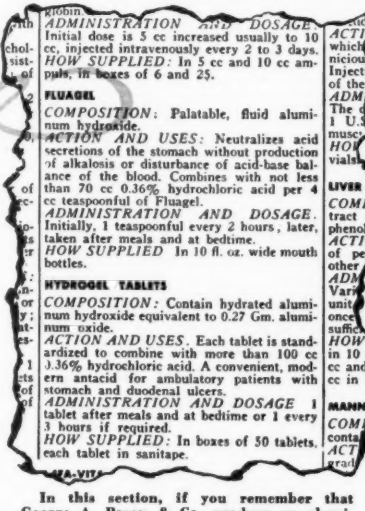
GASTRIC ULCERS
Al-Si-Cal (Smith-Dorsey), page 335
Alumnoid (Chatham), page 282
Amiogen—Parenteral (Christina), page 286
Aminonat (National), page 309
Aminovite (National), page 309
Barbidonna Tablets (Van Pelt & Brown), page 354
Belladenal (Sandoz), page 324
Bismaphen (Smith-Dorsey), page 335
Cal-Bis-Ma (Warner), page 356
Creamalin (Winthrop), page 360
Donnatal (Robins), page 323
Flint Eaton (Aluminum Hydroxide Gel), page 296
Fluagel (Breon), page 276
Gastridine (Specific Pharmaceuticals), page 337
Hydrogel Tablets (Breon) page 276
Kalak Water (Kalak), page 301
Kaopatch (Patch), page 316
Klim (Borden's), page 275
Ludozan (Schering), page 325
Malcogel (Upjohn), page 351
Malcotabs (Upjohn), page 351
Mesopin w/Phenobarbital (Endo), page

finding you remember that you had read or nd yo **about a product for the treatment of** y parti **ic ulcers and yet could not recall the** would **uct's name or its manufacturer, you** l **in all probability find it under the** ing **Gastric Ulcers.**

SECTION IV (White)

(Professional Product Information)

This section lists the major products of each manufacturer under the manufacturer's name. Complete information is given as to each product's composition, action and uses, contraindications, administration, dosage and how supplied. All information given in this section has been edited by the Medical Director of the manufacturer.



globin
ADMINISTRATION AND DOSAGE: Initial dose is 5 cc increased usually to 10 cc, injected intravenously every 2 to 3 days.
HOW SUPPLIED: In 5 cc and 10 cc ampuls, in boxes of 6 and 25.

FLUAGEL
COMPOSITION: Palatable, fluid aluminum hydroxide.
ACTION AND USES: Neutralizes acid secretions of the stomach without production of alkalosis or disturbance of acid-base balance of the blood. Combines with not less than 70 cc 0.36% hydrochloric acid per 4 cc teaspoonful of Fluagel.
ADMINISTRATION AND DOSAGE. Initially, 1 teaspoonful every 2 hours, later, taken after meals and at bedtime.
HOW SUPPLIED In 10 fl. oz. wide mouth bottles.

HYDROGEL TABLETS
COMPOSITION: Contain hydrated aluminum hydroxide equivalent to 0.27 Gm. aluminum oxide.
ACTION AND USES. Each tablet is standardized to combine with more than 100 cc 0.36% hydrochloric acid. A convenient, modern antacid for ambulatory patients with stomach and duodenal ulcers.
ADMINISTRATION AND DOSAGE 1 tablet after meals and at bedtime or 1 every 3 hours if required.
HOW SUPPLIED: In boxes of 50 tablets, each tablet in sanitape.

In this section, if you remember that George A. Breon & Co. produce an aluminum hydroxide item that is used in treating gastric ulcers, you could check through all of Breon's listings and find a detailed description of the product you had in mind.

is mo **Underwritten by the ethical pharmaceutical manufacturers and Medical Economics,** on of **., *P.D.R.* will give you finger-tip information as described above on ethical drug** ms. Keep *P.D.R.* on your desk. You will find many uses for it.

ECONOMICS, Inc.

RFOEW JERSEY

XUM

Group Practice: a Prognosis

Adverse effect on solo practitioner seen unlikely in expansion

How important is group practice going to become in the medical scheme of things over the next two or three decades? Judging by recent correspondence, there is considerable interest among American doctors in the group method as (1) a possible means of practice, or (2) as a source of competition.

Although it seems probable that there will be considerable increase in the number of groups, there is little to indicate that they will ever supplant solo practice entirely, even as a competitive method. In one typical area, which had a total of forty physicians twenty years ago, there is now a group of twenty doctors in addition to sixty solo practitioners, both G.P.'s and specialists.

One thing seems virtually certain: Mortality among groups in the next few years will not be so high as it was in the two decades following World War I. The period of experimentation is largely past. Successful, existing groups have accumulated vast stores of experience. Most of them are more than willing to share it with other physicians, even those who might offer competition. A number of agencies also have been (or are being) formed to offer groups expert counsel and guidance.

It was estimated, in the first article of this series (April MEDICAL ECONOMICS), that about 200 groups of four or more physicians practiced medicine privately in the U.S. Actually, no one knows with any degree of certainty, at the present time[1], just how many groups there are whose organization would conform to the following definition of true group practice:[2]

"Group medical practice is the application of medical service by a number of physicians working in systematic association, with joint use of equipment and technical personnel and centralized adminis-

► Because of increasing interest in group practice, MEDICAL ECONOMICS has undertaken an extensive study designed to cover all major phases of the operation of various types of groups. It is based on personal interviews with members of the groups discussed, and with other men who have had experience in the field.

[1]Several investigations are now being conducted, including one by MEDICAL ECONOMICS, which may serve to establish a reasonably accurate census.

[2]Committee for the Study of Group Medical Practice, 1940.

"the most common type of anemia encountered in the aged"

Stieglitz,* who found iron-deficiency anemia in approximately 70% of a group of patients over fifty years of age, stresses that "One must depend on iron medication and as near a normal diet as the patient can e

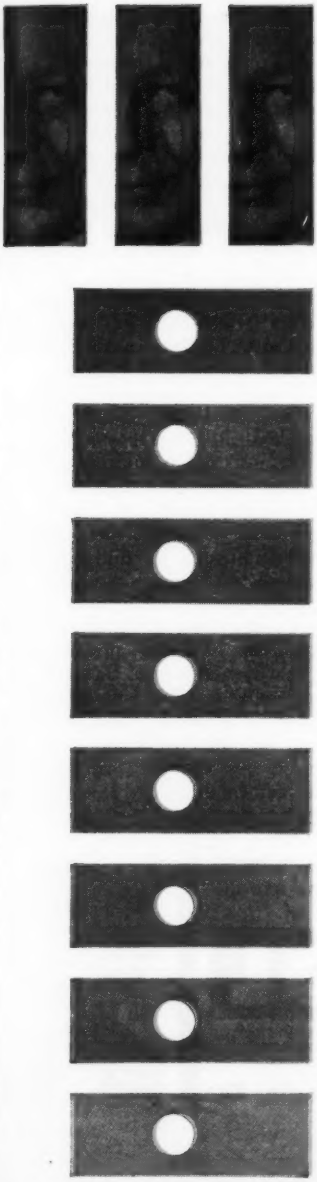
Feosol Tablets and Feosol Elixir provide adequate dosage of ferrous sulfate—grain for grain, the most effective form of iron therapy. They achieve the essential objectives of iron therapy: rapid hemoglobin regenerati and prompt reticulocyte response.

*Stieglitz, E. J.: Geriatric Medicine, Phila., Saunders, 1943, pp. 209, 825, 826.

Feosol Tablets *and* Feosol Elixir

The standard forms of iron therapy

Smith, Kline & French Laboratories, *Philadelphia, Pa.*



For simple hemoglobin determinations in preliminary diagnosis, the Fesosol Hemoglobin Scale is invaluable. The latest edition will be sent you promptly on your request.
Smith, Kline & French Laboratories, 429 Arch St., Philadelphia 5, Pa.

trative and financial organization."

Some feel that groups falling within that pattern number closer to 300 than 200, and if the definition were not applied too rigidly, the number would rise to about 500.

As a result of a MEDICAL ECONOMICS' mail questionnaire sent to a random list of about 600 organizations thought to operate as groups, and of the findings of Mr. Arthur E. Soderberg, group practice consultant, who was commissioned by this magazine to visit a number of groups throughout the country, the following observations can be made:

¶ The greatest concentration of groups is still in the Midwest.

¶ There are more groups in medium-size cities than in other types of communities.

¶ Most groups now in existence were formed between 1915 and 1930.

What of the future? There are still extremes of opinion, but of greater significance is the middle ground agreement that has developed. In the past, group practice was largely extolled and damned on idealogical grounds; today, the doctor who contemplates entering it generally makes his decision on the basis of whether in the long run it will be better for the patient and for him.

There are still those who believe that group practice will inevitably become the universal method, probably in conjunction with prepayment. Others think that such practice is not desirable for the vast majority of patients and is professionally stultifying. One thing appears certain: There is much misunderstanding about group practice and the manner in which it is operated. It was to clear up some of it that MEDICAL ECONOMICS initiated this current series of articles.

In 1944, 34 per cent of service physicians, queried by this magazine, indicated that they were interested in taking up group or partnership practice upon their return to civil life. Recently, in New York, more than 1,800 physicians signified their willingness to form groups to participate in the prepayment program of the Health Insurance Plan of Greater New York, which does not utilize individual practitioners.

It may not be true that "the isolated physician" no longer fits into the medical picture. The AMA Bureau of Medical Economics has stated that the G.P. can treat 85 per cent of his cases from his bag

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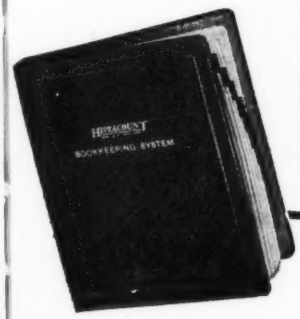

The ideal daily record system... simple as A B C... complete as A to Z. Devised by Certified Public Accountants, in collaboration with experts in the record-making field and based upon the doctor's actual need. Income tax, social security, and withholding tax records instantly available. Gives daily cumulative figures. You know your income and expenses and all other financial data immediately. "HISTACOUNT"... the greatest name in Doctors' Record Keeping...available at your Medical, Dental, or Surgical Supply Dealer.

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Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.

and refer the rest to competent specialists. But younger men, especially those who have seen military service, are inclined to ask themselves *how well* the G.P. can treat that 85 per cent. New drugs and therapy methods, constant technological advances, the evident expansion of specialism, all tend to raise vague doubts about the traditional mode of practice. In addition many men have become accustomed in military service to working conditions which they would like to retain in civil life: a wide range of consultative facilities, good technical equipment, shorter working hours, and greater opportunity for recreation and study.

In communities where groups have flourished, solo physicians have not suffered any major economic setback and they have, on the whole, become accustomed to working in competition with the new method. But others face this situation once described by Dr. Franz Goldmann:

"The appearance of group clinics was greeted by the medical profession with mixed feelings. Their potential value to the improvement and extension of medical care was realized. On the other hand, their impact on the practitioner in individual practice was dreaded. How could the physician working in a solitary office compete, scientifically and economically, with a team of men pooling their skill and practicing under the most favorable conditions?"*

The answer to that appears to be a simple one: The groups have attempted no test of strength with

*Franz Goldmann, Public Medical Care, 1945, p. 66 Quoted by permission of Columbia University Press.

Truly, this is America... the Doctor-Pharmacist Team

Friends as well as colleagues in healing, the doctor drops in to chat with the pharmacist.

IN EVERY American community the physician and the pharmacist are a team, combining their knowledge and skill to make this nation's health the finest in all the world.

The efforts of the physician rest on his certainty that the solutions he may inject ...the salve he may apply... the liquid or tablet he may prescribe, have been accurately dispensed by his pharmacist.

So, between these two servants of the people, a strong bond exists—fashioned in mutual interest for the well-being of those they serve. How truly American is this warm relationship of free men—each a master of his own craft, both eager to exchange news and information of their work.

It is by such initiative medicine follows the precept of one noted physician, who said, "...We must preserve, first, the Soul of Medicine, and second, Freedom in Medicine".

IN SUMMIT, New Jersey, a truly American community, Ciba constantly seeks to develop and supply the doctor and his partner, the pharmacist, with new drugs and new uses for established drugs. Thus Ciba shares in the progress of the doctor and the pharmacist and in the progress of free American Medicine.

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solo practitioners and the public has continued to patronize both.

While there has never been any official opposition on the part of organized medicine, it would be useless to deny that societies in the past have been cool, if not actually hostile, to group practice. But most of them now have come to the conclusion that the method is here to stay, and consequently that it should be accepted and supervised. A few have drawn up official codes which groups must meet to be acceptable, and it is highly probable that a great many others will follow suit. One or two, at least, are doing more than that: They are actively helping members, particularly veterans, who want to form groups.

It is probably true that in the last twenty years not quite so many groups have failed as have succeeded. Those which have won a niche for themselves have often won a large following. But it is doubtful that the public at large has developed any great amount of interest in group practice as a method of obtaining better professional service at lower cost. As will be seen later in this series, people who use groups have come to regard them in much the same way that other patients regard the solo doctor. Usually they deal with only one man in the organization. In all likelihood, few such patients are evangelists when it comes to spreading the gospel of group practice. There are notable exceptions, but these are generally concerned with group practice in combination with prepayment.

—ROSS C. MCCLUSKEY

WHY PHYSICIANS LIKE THE ALL-COTTON B-D ACE—NO. 1

- Because it's the original Ace Elastic Bandage that they have prescribed successfully for many years for the treatment of varicose veins and ulcers, strains, sprains, and injuries.
- Because previous use has taught them that Ace offers effective relief for their patients' ailments.
- Because its all-cotton construction permits support without constriction.
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WHY THEY LIKE THE ACE — WITH "LASTEX"* — NO. 8

- Because some physicians prefer an elastic bandage containing rubber — especially where motion of the part to be wrapped might cause slipping or loosening of the bandage.
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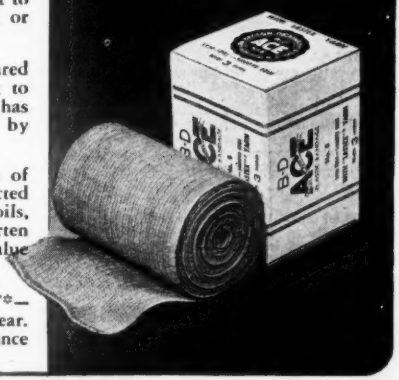
- Because the Ace—With "Lastex"*—No. 8 is cool and comfortable to wear. Its skin-tone shade is an appearance factor.



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Positions Wanted by Physician-Veterans

Any physician returning to civil life from the armed services or from a war agency may insert *free* in MEDICAL ECONOMICS (circulation: more than 125,000) a position-wanted ad of up to 24 words. The following data, which will be kept confidential, must accompany ad copy: name, address, rank or position, date. Copy must reach MEDICAL ECONOMICS before the 5th of the month preceding publication. Address: Veterans' Editor, Medical Economics, Inc., Rutherford, N.J.

AMERICAN BOARD OF SURGERY credit desired; age 33; diplomate national board; require only 15 months' work under diplomate in approved hospital to qualify; now in N.Y. Box 1714.

ASSISTANTSHIP or association with urologist desired; 3½ years' hospital training, including 18 months of urology, 1 year of general surgery, and a 1-year rotating interneship; also 2½ years' Army experience; now in N.Y. Box 1645.

ASSISTANTSHIP to internist, salaried position with group, or opportunity to share office in N.Y.C. desired. Box 1709.

ASSOCIATION, group practice, or private practice desired; experienced in chest disease and physical medicine; aged 34; Conn. and Mich. licenses; now in Conn. Box 1717.

DERMATOLOGIST; certified; age 33; desires midtown Manhattan office; share expenses; invest in new office, group, or association. Box 1638.

OBSTETRICIAN-GYNECOLOGIST desires approved residency or association with American board diplomate; now in Pa. Box 1691.

OBSTETRICIAN-GYNECOLOGIST desires association with group or individual; national board diplomate; age 34; excellent references; now in Md. Box 1706.

GENERAL PRACTICE or assistantship desired in either N.J. or N.Y.; now in N.J. Box 1719.

GENERAL PRACTITIONER desires part-time industrial position; will also consider assistantship; age 39; N.Y. and N.J. licenses; now in N.Y. Box 1713.

GENERAL PRACTITIONER desires tuberculosis clinic or small sanitarium; 4 years' therapeutic and diagnostic experience in T.b.; 5 years' general practice; age 35; now in Ill. Box 1718.

INDUSTRIAL PHYSICIAN; desires position or assistantship in eastern state; age 36; 4 years' hospital experience; now in Pa. Box 1707.

INDUSTRIAL position desired; age 35; N.Y. license in both medicine and dentistry; now in N.Y. Box 1712.

INTERNIST; age 29; desires assistantship to general practitioner; has had approved rotating interneship; 30 months in Army as internist and surgeon; now in N.J. Box 1716.

ORTHOPEDIC assistantship with American board diplomate desired; 2 years' excellent training and experience; superior school and interneship; age 30; now in Ill. Box 1711.

PEDIATRICIAN desires assistantship or residency; Calif. or Ill. location preferred; available after Nov. 1; now in Ill. Box 1715.

STUDENT HEALTH appointment sought in New England; age 36; diplomate national board; 3 years' experience director, inspector, lecturer, hygiene, sanitation, V.D., to 15,000 troops; also qualified in minor surgery. Box 1710.

SURGEON; assistantship with FACS or board surgeon desired; age 30; 2 years' university surgical training; 20 months' Navy; So. Calif. preferred. Box 1708.

ITCH in 1800

may *have been palliated by assembly-line cooperation, as drawn by a humorist with Napoleon's army. For relief lasting a little longer, soldier and citizen* did *depend upon a mixture of lard and gunpowder.*

The 1946 agent is BENYLATE-*Breon. One application usually eradicates scabies as well as head lice and body lice.*

Benylate is a lotion of benzyl benzoate 25% in triethanolamine stearate. White, cleanly, greaseless, it requires no dilution but is ready to apply for quick relief from itching; it penetrates skin crevices with lethal effect on mites.

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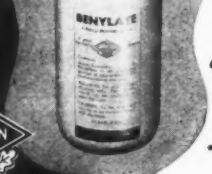

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Veterans Get Wider Insurance Choice

New law provides for endowment policies, lifts restrictions on beneficiaries

Physician-veterans, more insurance-minded than most ex-servicemen, may seem to find in the recently liberalized National Service Life Insurance Act considerable inducement to convert "from temporary wartime coverage to a permanent policy." Congress has made available to veterans several "popular" types of policy at rates lower than those offered by commercial insurance companies. But M.D.-veterans would do well to weigh the matter carefully before deciding to make any change.

Affected by this amendment are three classes of veterans: (1) those who have already converted their temporary wartime insurance contracts to a permanent basis; they may now reconvert to a more attractive policy; (2) those who have let their contracts lapse; they may reinstate them and convert; and (3) those who served in the armed forces between October 8, 1940 and September 2, 1945, but who did not buy NSLI while in service; they may purchase a new policy. In all cases, total face value of insurance is limited to a maximum of $10,000.

As originally issued, NSLI was convertible to one of the following policies: (1) ordinary life; (2) 20-payment life; (3) 30-payment life. All three possibilities are still available. For ordinary life, you pay premiums as long as you live. For 20- or 30-payment life, you pay premiums for twenty or thirty years, and your policy has been paid in full.

Policies now available under the new law are 20-year endowment, endowment at age 60, and endowment at age 65. At the end of the required time the Government will pay you full face value. Meantime, your beneficiary has been protected—but at extravagantly high cost to you.

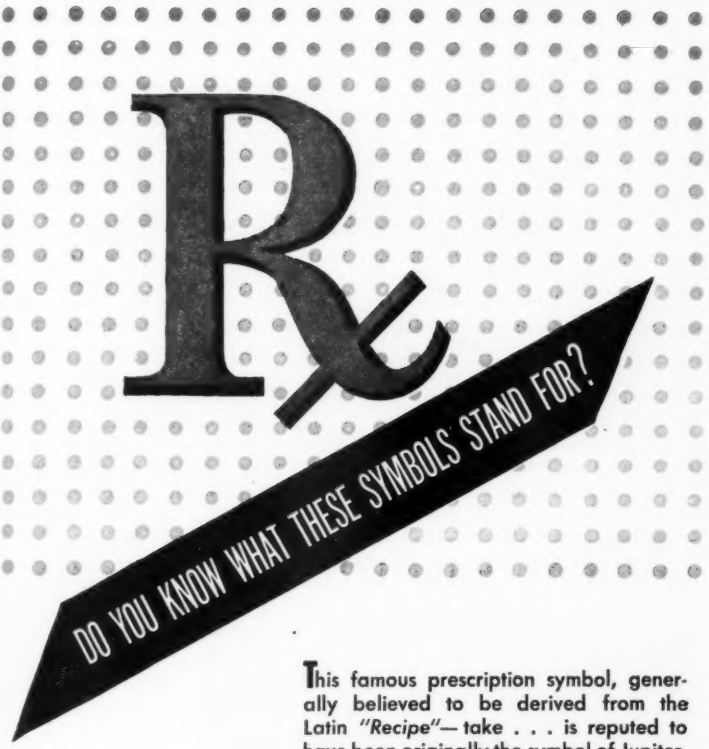
It is at this point that the physician-veteran should do some basic thinking. Are you purchasing life insurance primarily as protection for your dependents or are you utilizing it as a savings method? If your investment is for protection, the liberalized program has little real attraction. According to the present statute, you must convert your wartime term policy within eight years of your initial payment on it (within five years if you purchased it after December 31, 1945). Thus, you have more than adequate time to make the change-over, and there will be little increased premium cost if you wait. If you are now 30, the premium on the 20-year NSLI endowment

policy is $41.55 per $1,000 each year; if you wait five years to convert, it will cost you $42.15 a year. Meantime, you can have full coverage under your term policy at a fraction of that cost. In fact, if you are interested in protecting your beneficiaries, you should retain this wartime term policy for just as long as you can. It is quite possible that the Government will do again what it did after the last war: change the law so that a veteran may renew his low-cost term policy every five years as long as he lives.

Except under most favorable circumstances, the average physician would do better to purchase life insurance only as protection for his family, and to set up a separate and distinct savings program. The history of endowment insurance is one of non-fulfillment—the average person buys such insurance in a moment of good intention, but later, by force of circumstances, he lets it lapse. Actually, only an infinitesimal percentage of all endowment insurance matures while the insured lives. As protection for the widow or orphan, it is the worst possible buy, for you pay an exorbitant price for it.

Perhaps, in spite of this reasoning, you would still like to convert, but feel that the new premium would be difficult to carry at the present time. In that case, you should continue your monthly payments on the NSLI term policy until your financial position improves; then the premium load you are able to carry must determine the type of insurance which you will choose. If you decide to convert, use V.A. Form 358.

[*Continued on page* 174]



This famous prescription symbol, generally believed to be derived from the Latin *"Recipe"*— take . . . is reputed to have been originally the symbol of Jupiter. This symbol was placed at the top of a formula to propitiate the king of gods in order that the compound might act favorably.

Almost as famous, but rooted purely in science, is the 43-year-old Rexall symbol of dependable drug service—displayed in selected and conveniently located pharmacies throughout the nation. It is a sign that fine Rexall drugs and expert pharmacal ability are at your service.

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UNITED-REXALL DRUG CO.
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Government rates vary just as those for any other insurance do, according to the age of the insured when the policy is issued except at extremes of age when the rate variation is not great. One age example illustrates the relative cost of the various policies: At age 35 the annual premium for a $10,000 NSLI term contract is $90 annually; for ordinary life, $213.10; for 20-payment, $299.50; for 30-payment, $240.30; for 20-year endowment, $421.50; for endowment at age 60, $333.90; and for endowment at age 65, $280.60.

TOTAL DISABILITY BENEFITS

Another new feature is the payment of benefits to any insured person who has been totally disabled for at least six months. These payments which are effective from the first day of the seventh month, are at the rate of $5 a month for each $1,000 of insurance, and are payable as long as total disability exists. Face value of the policy is not affected by such payments. Beneficiaries receive full policy value upon the death of the insured. This disability protection, limited to those who can meet specified health requirements, may be added to any NSLI policy upon payment of an additional premium. (Note that a service-connected disability which is less than total does not bar you from enjoying this added protection.)

BENEFICIARY ADVANTAGES

The amended law offers still other advantages. Formerly you could name as beneficiary only your spouse, parent, sister, brother, or child. Now all restrictions have been removed. You can designate

any person or corporation, or have the proceeds made payable to your estate. And you can change the beneficiary at any time without special permission.

Under the original law, the only methods of settlement provided were (1) monthly income or annuity payments for a guaranteed period of 120 months or (2) "refund life income," paid in equal monthly installments with the guarantee that the face of the policy would be repaid. These methods are still available, but there are other options: (3) lump-sum payment of face value to the beneficiary and (4) equal monthly payments ranging, at your stipulation, from 36 to 240 months. Of the four payment methods listed, only the first two require an explanation.

Under No. 1, a widow less than 30 collects $55.10 a month for 20 years upon a $10,000 policy, or an aggregate of more than $13,000. (Under a $5,000 policy she would get $27.55 a month, and so on down the scale.) A widow 30 or over receives for the rest of her life, monthly payments calculated according to her age at your death; if she dies within 10 years, payments to her beneficiary will be continued until 120 have been made. This feature is known as the "10-years certain" clause, because the secondary beneficiary (or your estate) is sure of payments for the balance of the 10-year period remaining after the death of the No. 1 beneficiary. Here are some examples of what your beneficiary would collect monthly on a $10,000 ordinary life policy (others in

"When a patient shows symptoms of O.O.*...always recommend Astring-O-Sol...three times a day!"

PHYSICIANS AGREE on the effectiveness of Astring-O-Sol as a mouth wash for cleansing and stimulating oral tissues.

When used at full strength, it is a germicide... useful for minor surface cuts.

Astring-O-Sol is concentrated to last longer... just a dash in a glass of water makes an excellent mouth wash with a refreshing flavor.

Samples are available to the profession, upon request.

*Oral Offense

ASTRING-O-SOL

EFFECTIVE MOUTH WASH

Frederick Stearns & Company *Division*, Detroit, Michigan

proportion), according to his or her age at your death:

31..	$40.10	50..	$53.90
35..	42.00	55..	60.30
40..	45.00	60..	68.10
45..	48.90	65..	76.70
70....	$85.10		

Because of the variation in benefits, a prudent family head may consider a change in beneficiary. For instance, if your mother were beneficiary and age 70 at your death, the monthly payment of $85.10 would be continued for at least 10 years, and longer if she should live beyond that time. She wouldn't be likely to survive much beyond 80, so the total amount paid ($85.10 x 120 payments) probably would amount to $10,212. But if your wife were beneficiary, and 45 at your death, she would be paid $48.90 a month. Given a life expectancy of 24 years, her aggregate would be $14,083.

Method No. 2 provides for the beneficiary a "refund" life income, as opposed to the "10-year-certain" plan described above. For any beneficiary whose age is such that payments made to him for ten years total less than $10,000, the "refund" option is available. Under it, the beneficiary receives the slightly smaller income $39.50 at age 35 instead of $42.00, $50.40 at age 50 instead of $53.90, etc., but the payments continue after the premature death of the original beneficiary, until the full $10,000 has been paid out. This option is not offered to beneficiaries over 69, since the 10-year-certain plan guaranteed total payments in excess of $10,000.

[*Continued on page* 180]

Many insurance consultants consider the 120-month plan undesirable except when the beneficiary is a child or a young person. They point out that the aggregate of 120 monthly payments, about $7,000, is never as much as the face amount. The beneficiary must live a considerable time after ten years in order to collect the face value of the policy. The refund-life-income option is a much better buy, for it means that the beneficiary, or the beneficiary's estate, will collect an aggregate of at least $10,000. For a beneficiary in middle life, the equal-monthly-payment arrangement (No. 4 above) is an excellent one, for it will return an aggregate of about $12,000.

Incidentally, the monthly payments to beneficiaries are exempt from income tax levy and from legal seizure, garnishee, or attachment.

LOANS ON POLICIES

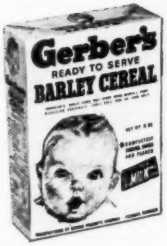
The original Government wartime term policy has no cash surrender or loan value; converted policies do have such value after they have been in force one year. Here is your equity in a $10,000 ordinary life policy, issued at age 30, after passage of the number of years indicated:

1	$104.90	5	$ 557.30
2	213.10	10	1,201.00
3	324.50	15	1,936.10
		20	$2,760.20

You can borrow up to 94 per cent of the cash surrender value by making application on V.A. Form 1547. Since such a Government loan costs you 5 per cent interest, it may be wise to seek cheaper rates.

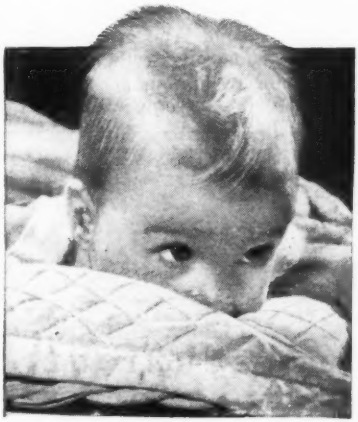
NSLI policies, like commercial ones, lapse for nonpayment of pre-

New Food for Babies...



THE LATEST ADDITION to Gerber's specially-for-baby cereals is *Barley Cereal.* It's now being warmly welcomed by both mothers and doctors.

Made from fine barley flour, this new cereal is enriched with added iron and dried yeast (a rich source of thiamine and other vitamins of the B complex). These additions bring the nutritive values of Barley Cereal above that of the whole grain. Calcium and phosphorus have been added for the protection of those babies who are not receiving adequate amounts of milk.



Along with Gerber's Cereal Food and Gerber's Strained Oatmeal, Barley Cereal gives mothers the choice of three special cereals for babies. Many mothers report that serving variety improves baby's appetite.

Like the other two Gerber's Cereals, Barley Cereal is precooked, ready-to-serve by adding milk or formula. Essentially free from crude fibre, it is easily digested by infants as young as a month old and may be used as a starting cereal as well as right through the pre-school years.

Gerber's Barley Cereal is priced within the reach of every mother.

Professional reference cards and samples of Gerber's Barley Cereal will be sent you on request. The coupon below is for your convenience.

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Baby Foods
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GERBER PRODUCTS COMPANY
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Gentlemen: Kindly send me complimentary samples of Gerber's Barley Cereal as well as samples of Gerber's Cereal Food and Gerber's Strained Oatmeal and Professional Reference Cards.

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City.....State.....

miums. And you may have to undergo a physical examination to gain reinstatement.

If you become totally disabled, premium payments are waived for the duration of your disability (unless you are over 60 when the disability begins). Payments are waived although you may be drawing pension, retirement, or leave pay at the time. Nor does waiver of premium impair the value of the policy in any way.

REMITTANCES

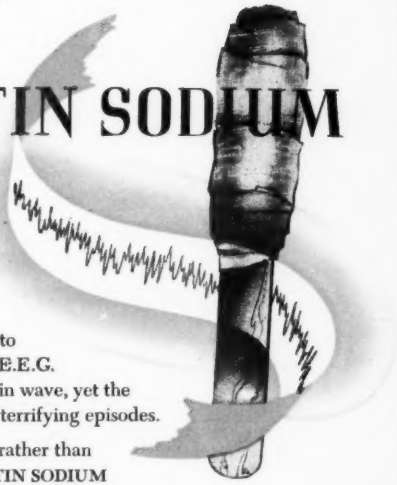
In making your remittance for a premium, make your check payable to the Treasurer of the United States and mail it to the Collections Subdivision, Veterans Administration, 346 Broadway, New York 13, N.Y. All other correspondence, including requests for data on rates, should be addressed to Insurance Division, Veterans Administration. Washington 25, D.C.

While you were in service, you probably arranged to have premium payments deducted from your salary check. It is cheaper, however, to make payments quarterly, semi-annually, or annually. Just notify the Collections Subdivision how often you wish to remit, and it will inform you of the correct amount. (If you are collecting retirement pay or a pension, the Government will deduct premiums from your check.)

Your policy number is on the certificate issued in lieu of a policy, and is also on the counter-receipt you received when you made your initial payment. You can simplify correspondence with the V.A. if you indicate that number on all your letters. —HOWARD CLANEY

SYMBOLS OF SIGNIFICANCE

DILANTIN SODIUM



The cry, the fall,
the champing teeth,
the tonic and clonic
contractures, the
incontinence—all may yield to
DILANTIN SODIUM. The E.E.G.
can trace the pathologic brain wave, yet the
epileptic may be spared his terrifying episodes.

Powerfully anti-convulsant rather than
dullingly hypnotic, **DILANTIN SODIUM**
KAPSEALS* offer to the epileptic a
sense of security and an opportunity to
lead a more normal and useful life.

DILANTIN SODIUM KAPSEALS—another product of revolutionary importance in the treatment of a specific disease; another of a long line of Parke-Davis preparations whose service to the profession created a dependable symbol of significance in medical therapeutics—**MEDICAMENTA VERA.**

DILANTIN SODIUM KAPSEALS (diphenylhydantoin sodium), containing 0.03 Gm. (½ grain) and 0.1 Gm. (1½ grains), are supplied in bottles of 100, 500 and 1000. Individual dosage is determined by the severity of the condition.
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control . . .

Control of capillary and venous bleeding reduces blood loss during operative and postoperative period procedures. Therapeutically for use in the control of bleeding in hemoptysis, epistaxis, bleeding ulcers, hematuria, the purpuras and hemophilia. KOAGAMIN* diminishes blood loss by the patient. Saves time for the physician.

Our laboratory control of KOAGAMIN assures you of a pyrogen free, non-toxic product. KOAGAMIN may be injected either intravenously or intramuscularly. Supplied in 10cc vials. KOAGAMIN remains stable indefinitely.

Literature and bibliography on request.

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Choosing the Right Neighborhood

Here are a number of points to investigate before making your decision

"I've picked the city in which I want to practice," says a young physician, "but I'm stumped when it comes to choosing a neighborhood. Should I open a downtown office? Should I move into a residential district? Would it be wise to find a spot in one of the neighborhood shopping centers? What factors should I consider in weighing advantages and disadvantages of each locality?"

A week or two of investigating the following major considerations may be time well spent. A bad guess can nullify your chances for a successful practice.

Ordinarily the specialist should be located downtown—or at least reasonably near the main shopping section. Patients seen by appointment generally combine a visit to the doctor with a shopping tour, a luncheon date, or an afternoon at the movies.

▶ These are not happy hunting days for physicians who want new offices, but it will not always be so. This article will help you to measure a neighborhood for that new location when you can find it.

The G.P., on the other hand, should be situated in the residential district. Unlike the specialist, he must be where his sign will be noticed, where people can walk in during office hours, and where he can be reached easily from the home at a time when husband and wife can see him together. The one exception is the well-established G.P. who has a large neighborhood practice and a yen for a downtown office. Most patients will follow such a man. But the beginner with no backlog is likely to find the business district something of a desert; his sign will go unnoticed. It may take a long time (at high rentals) for him to gain a following.

In a middle-class residential district, it's usually wise for the G.P. to be near the heart of the neighborhood marketing zone on a street served by the main trolley or bus line. Thus, people going downtown, as well as those shopping in the neighborhood, get to know the newcomer's location.

In smaller communities (less than 10,000 population) the preferred spot for any physician is generally the central business district or a side street close to it. Like neighborhood shopping centers in large cities this location is

both convenient for public transportation and accessible for patients from surrounding rural areas.

Though figures on per capita income are rarely available for so small a unit as a neighborhood, in some areas Better Business Bureaus have reliable estimates. Besides income statistics, other good yardsticks are: (1) residential rent-range of the area; (2) ratio of home-owners to tenants; (3) approximate percentage of families having cars and telephones; and (4) quality of the retail shops, particularly food markets. Well-patronized quality food shops are excellent indices of the level of neighborhood prosperity. Here a woman's judgment is often more reliable than a man's.

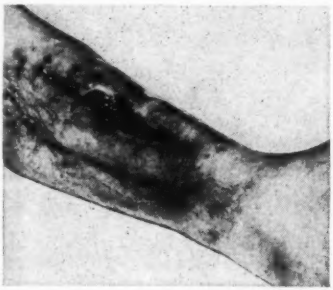
If a neighborhood has a progressive-minded merchants' organization, a "boosters' club," or Chamber of Commerce, that's a healthy sign. Presence of an alert parent-teachers' association indicates that the people of the neighborhood are the civic-minded kind who want good schools and good medical care.

Many doctors have established successful practices in low-income sections. In such districts, the disadvantages (low fees, long hours, hard work, and poor living accommodations for one's own family) are often offset by these advantages: low rent, variety of cases, cash payment in many instances, a large practice, and a high degree of respect on the part of patients.

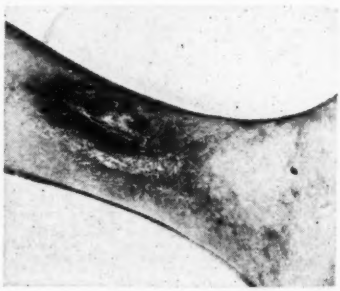
In an area adjacent to an industrial section, the physician's practice will invariably depend upon the prosperity of the nearby fac-

CHLOROPHYLL THERAPY

Evidence reported by leading clinics confirms the definite *healing, deodorizing* advantages of Chloresium, therapeutic chlorophyll preparations



Chronic Osteomyelitis of several years' duration—extremely malodorous and painful. One of hundreds of cases of ulcers, osteomyelitis, skin diseases and burns in which well-known clinics observed effects of Chloresium. LAHEY CLINIC BULLETIN, April 1946, reported: "(Chloresium) apparently excels previously used agents for local treatment of chronic ulcers."



Treated with Chloresium Ointment by packing on alternate days for six weeks, following "cleaning up" of infection and malodor by wet dressings of Chloresium Solution for 48 hours. The GUTHRIE CLINIC BULLETIN, July 1946, reported: "We have used (Chloresium) in a variety of conditions, particularly in burns, chronic ulcers and osteomyelitis, with splendid results in a vast majority of cases."

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Chloresium is ethically promoted. Available at all leading druggists

Chloresium Solution (Plain) 2-oz. and 8-oz. bottles
Chloresium Ointment . . . 1-oz. tubes and 4-oz. jars
Chloresium Nasal Solution . . . ½-oz. dropper bottles and 2-oz. and 8-oz. bottles

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Please send me a copy of "Chlorophyll—Its Use In Medicine." (Clinical samples will be sent if requested on your letterhead.)

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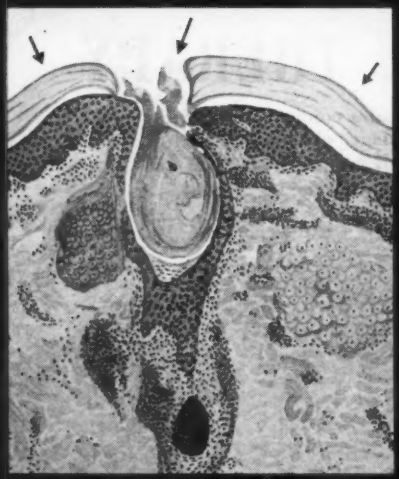

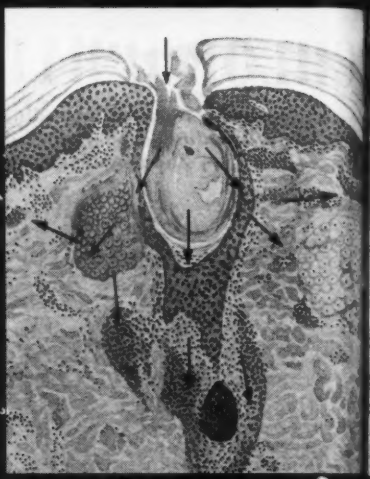

TYPICAL PATHOLOGY OF ACNE VULGARIS

Why routine preparations fail. Yellow color shows the usual inadequate penetration of ointments and other topical medications. There is no effective concentration of medication at main site of infection. Lesions may persist even after prolonged treatment.

Intraderm Sulfur in new skin penetrant vehicle saturates the entire pathological area in and around the follicle. The deepest lesions are impregnated with effective concentrations. This is why Intraderm Sulfur is successful even in stubborn cases.

How You Get Quicker Healing with Intraderm Sulfur Solutio

To heal stubborn acne vulgaris cases faster, use Intraderm Sulfur Solution.

The illustrations above tell why Intraderm Sulfur is so effective. It deposits highly active sulfur in the acne lesions, *right down in the follicles and sebaceous glands.*

This treatment combines the new principle of skin penetration with the well-established effective action of sulfur in acne.

Extensive clinical studies[1] have proved the efficacy and safety of Intraderm Sulfur.

Intraderm Sulfur Solution consists of 0.75% polysulfides in a fundamentally new, skin-penetrating vehicle designed to allow preferential action of sulfur at the sites involved in acne vulgaris.

Joint action of the chemical and physical properties of Intraderm Sulfur produces these results:

Increased hyperemia, enhancing the natural defense mechanisms.

Keratolytic action, stimulating surface de quamation and softening keratin blocka in the follicles.

The solvent action of the vehicle soften the foreign matter (dirt and oxidized s bum) in the follicle, while the effecti wetting agents aid in its removal.

The medication kills the organisms us ally associated with acne.

Intraderm Sulfur is well-tolerated, a **above all, easy to use because:**

1. It leaves no unsightly areas: no wh disfiguring mask—no greasy surface—aft application.
2. It can be used day and night, thus a suring continuous sulfur effect.
3. It is an excellent skin cleanser.
4. Each application takes only a few mi utes.

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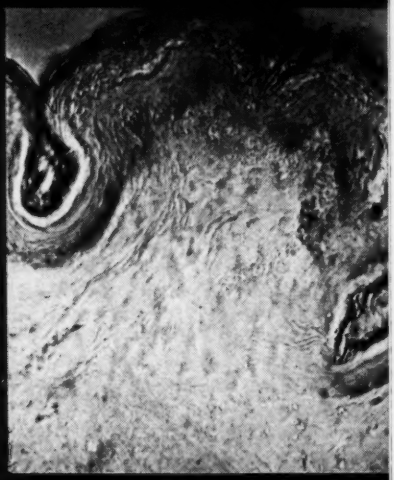

TESTS FOR PENETRATION OF VEHICLE

Non-penetrating base. Guinea pig skin inuncted with lanolin ointment, containing tracer substance. Yellow color shows material containing tracer on surface with only slight impregnation of the horny layers. Ointments studied *did not permit skin penetration.* Photo made from Kodachrome original.

Human skin inuncted with Intraderm Sulfur vehicle containing tracer substance. Material (yellow stain) impregnating follicle, cutis and epidermis. Below upper horny layers is a color-free band along stratum lucidum, indicating site of barrier to penetration. Photo from Kodachrome original.

INFECTED SITES EASILY REACHED

Intraderm Sulfur Solution penetrates the weak spot in the skin's electro-physical barrier[2]. The combination of the ingredients in the Intraderm Sulfur vehicle effects penetration down the follicle into the cutis.

Developed specifically for acne, the effectiveness of Intraderm Sulfur can be summarized as follows:

1. Penetrates normal and diseased follicles, enhancing general sulfide action.
2. Causes mild hyperemia, increasing natural defense mechanisms.
3. Stimulates surface desquamation (mild peeling cure).
4. Softens and removes keratin plugs that block follicles.
5. Effectively aids thorough cleansing of follicles.
6. Bactericidal for organisms in acne.

1. *MacKee, Wachtel, Karp and Herrmann, Jour. Invest. Dermat. 6, 309, 1945*
2. *MacKee, Sulzberger, Herrmann & Baer, Jour. Invest. Dermat. 6, 43, 1945*

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Please send sample and literature on Intraderm Sulfur.
Doctor_____
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Limited to Medical Profession in U. S. A.

Physicians the world over rely on this easily tolerated, outstandingly palatable tonic to restore appetite, vigor and general tone . . .

Eskay's Neuro Phosphates . . .
clinically
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tories. Generally speaking, diversification is a good sign, for one-industry neighborhoods suffer the same slumps as one-industry towns. Frequency of strikes is not necessarily a bad sign, because strikes mean that labor is organized, can command better wages, and is not forced to accept lower pay scales with every business setback.

In estimating the stability of a neighborhood, don't overlook the effects of continued reconversion. Unless the character of the business carried on there is fairly stable, the district may suddenly become a deserted village.

In most cities, the natural "clannishness" of people causes them to live in areas that have some racial, linguistic or even religious appeal. Choice of location should be checked against your own background, racial strain, and knowledge of languages. Quite often the most successful doctor in a neighborhood will be the one whose background is identical with that of the majority of residents.

If you intend to live as well as practice in the neighborhood, you will wish to consider these factors:

1. What schools are available? Is there a public library convenient? Is the area provided with playgrounds and other recreational facilities?

2. Will your family be able to do its shopping close-by?

3. Will you have an adequate opportunity to take part in community affairs? To pursue a hobby?

4. What welfare groups are active in the neighborhood? Are they the kind that you can join or work with to your advantage?

5. Does the neighborhood offer future possibilities for buying or building a home?

6. How do living costs compare with those in other sections of town?

—R. G. SHUTE

John L. Lewis vs. Doctors

[*Continued from page* 58]

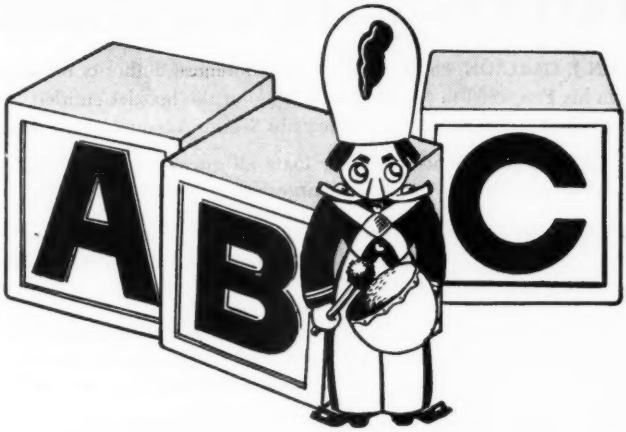
that each call may bring him less than 50 cents.

At their worst, mining towns are so repulsive that only the most self-sacrificing doctor could work in them. This reporter inspected one of the more backward towns a month ago. It stretched for a mile or more along the banks of a dirty, ill-smelling little stream. Over its rutted dirt road, pigs, cattle, and chickens roamed at will. Almost without exception its houses were tumble-down structures not fit for human habitation. Only one, that of the union local's president, was painted and trim looking.

There was no sewerage system, no running water. Garbage and refuse littered most front yards. Here and there, a primitive privy, built for community use, stood beside the road. The only available water supply was the seepage from an abandoned mine, and the pigs and other animals drank at the same pool in which the miners' families filled their buckets. In the cabins, vermin crawled about unhindered, unnoticed.

Towns like these must be on a physician's list if the people are to receive care. Trouble is, there are too many of them for the number of doctors available.

Last month, Navy doctors under the direction of Admiral Joel T. Boone were completing a survey of the medical, hospital, sanitary, and housing conditions in the mining areas—a project generated by the Krug agreement. That their report would be a dismal one, few people doubted. —KENT BARSTOW



A B C Treatment for Skin Disorders

THE Mazon Treatment, employing Mazon Soap and Mazon Ointment—as simple as A-B-C—acts swiftly to bring dramatic results alleviating many stubborn skin disorders. Briefly the treatment is as follows:

A. Cleanse the affected area with Mazon Soap.

B. Rinse thoroughly. Dry.

C. Apply Mazon Ointment.

INDICATIONS

Indications include Eczema, Psoriasis, Alopecia, Ringworm, Dandruff, Athlete's Foot and other skin irritations not caused by or associated with systemic or metabolic disease.

MAZON SOAP

Mazon Soap is 100% pure, contains no free alkali, artificial color, synthetic perfume, excess oils or greases to retard or nullify the therapeutic action of its complement, Mazon Ointment.

MAZON OINTMENT

Mazon Ointment itself is absolutely antipruritic, anti-septic and anti-parasitic. It is easy to apply, is non-greasy and non-staining and requires no bandaging.

CLINICAL STUDIES

Many clinical studies proving the success of the simple Mazon Treatment are in our files. Its record of success suggests your own trial.

MAZON

OINTMENT **SKIN SOAP**

FOR EFFECTIVE DERMAL THERAPY

BELMONT LABORATORIES CO., PHILADELPHIA, PA.

NUTRITION—vouched for by top nutritioni

ANTON J. CARLSON, Ph. D., M. D., world's foremost authority on nutrition, says in his Foreword to the Revised Edition of the booklet entitled "Legislation Which Renders It More Difficult to Secure Adequate Nutrition":

> **"The facts at hand today eliminate all questions as to the nutritive value of vitamin A fortified margarine[1] as compared to butter . . ."**

THE COUNCIL ON FOODS AND NUTRITION of the American Medical Association, in a report published in the Journal of the American Medical Association, Sept. 16, 1944, says:

> **"When margarine is fortified with vitamin A[1] the investigations that have been made lead to the conclusion that it can be substituted for butter in the ordinary diet without any nutritional disadvantages."**

[1] Nucoa, the first margarine to add Vitamin A, guarantees 15,000 U.S.P. units in every pound, winter and summer. This is 6,000 units above the minimum for fortified margarine as established by Federal Standard of Identity.

FLAVOR—vouched for by millions who enjoy

1941

1946

Typical of the satisfaction that Nucoa, Amer most popular margarine, gives is the enjoymer Nucoa in the home of the children pictured at Nucoa has been the Madeira family's chosen sp for bread for about twenty years. Says Mrs. Mad

> **"Our use of Nucoa, begun for economy, has continued for pleasure. We like Nucoa's dep ably fresh flavor and nourishing goodness, and fact that it contains a guaranteed amount of V min A, winter and summer. My children's growth, and their alertness and success in sc and play, give me confidence that our diet, in ing Nucoa all these years, has been well selec**

Why not try Nucoa in *your* home? It will give confidence, we believe, in encouraging wider u margarine—for enjoyment as well as good nutri

Nutritious NUCOA

NOW WITH 15,000 U.S.P. UNITS OF VITAMIN A

The Newsvane

Army Gives Internes Big Salary Boost

Civilian hospitals stand to lose a considerable number of prospective internes to the Army next year since the War Department has offered to commission 1947 graduates as first lieutenants if they elect to serve their interneships in Army hospitals. Heretofore, internes have been paid only $1,000 a year, because they have been classified as civilian employes. As officers, they will receive $3,404 if they have dependents, $2,972 if they have none. Upon completion of an Army interneship (which is recognized by the AMA) the physician may elect to stay in the Army or leave it. Each applicant must be a citizen, not over 30 by July 1, 1947, and a graduate of an approved medical school.

FBI Seeks False Doctor Accused of Lewdness

Missouri physicians have been warned to be on the lookout for a man posing as a physician, who has exhibited "depraved pleasure" in discussing sex matters over the telephone with married women, and who is currently being sought in St. Louis by the FBI.

G. B. Norris, a Federal agent, thought that an imposter who had been reported as a "Dr. Marshall" or "Dr. Kelly" might be the same man who, under pretense of seeking data about birth control for the Government, had induced a housewife to discuss intimate details of her sexual relations with her husband and eventually to submit to a physical examination.

Agent Norris said that the FBI had received a number of reports about still another individual who had phoned women recently discharged from maternity wards, had pretended to be an interne, and had attempted to get the women to discuss sex with him.

Child Welfare Services To Be Expanded Soon

Katharine Lenroot, chief of the Children's Bureau of the Federal Security Administration, predicts that child welfare services will be greatly expanded throughout the nation. Congress has provided, by the Super-EMIC compromise, additional appropriations which will make it possible for the bureau (1) to employ full-time workers in areas where none now work, and (2) to increase the funds already available in several states (e.g., Texas, $165,363 annually, up $96,339; California, $103,194, up $59,415; Illinois, $106,607, up $61,442). Under previous appropriations, each state received a flat $20,000 grant-in-aid from the Federal Government, plus

an additional sum based on its rural population.

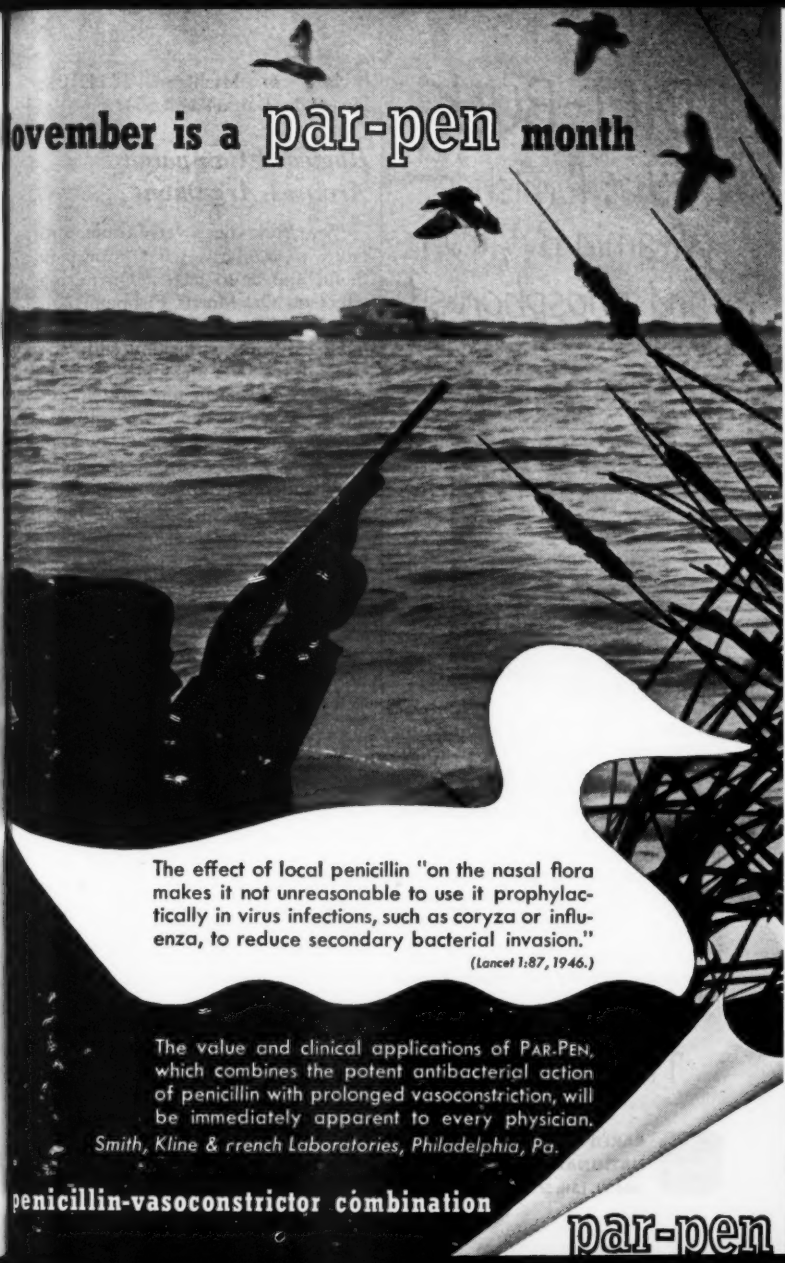
"This is a welcome prospect," says Miss Lenroot, "for five out of six counties in the country today have no full-time child welfare workers." She adds that while states will decide how funds are to be spent, much of the money probably will be used to find foster homes for children; to assist in the care of orphans, wards of juvenile courts, and children with behavior problems or mental handicaps; and to help unmarried mothers.

Hospitals' Expenses Top Rates Charged Patients

The average patient in a nonprofit, general, civilian hospital pays $1 a day less than the cost of his care, according to the 1946 edition of the American Hospital Directory. Total hospital expenditures for each patient averaged $8.95 per day for the year which ended Sept. 30, 1945. Income from patients averaged $7.95 a day, from all sources $9.51. A breakdown by size of hospital produces the following average patient-day costs:

Less than 50 beds	$7.38
50-99 beds	7.84
100-249 beds	8.70
More than 249 beds ..	10.07

Compared with the average of $8.95 spent by nonprofit hospitals, Government institutions had a patient-day cost of $7.56, proprietary institutions, $8.52. In all, payroll expenditures represented from 50 to 60 per cent of costs. Highest total expenditures per patient-day were in California ($12.87); next


ovember is a par-pen month
The effect of local penicillin "on the nasal flora makes it not unreasonable to use it prophylactically in virus infections, such as coryza or influenza, to reduce secondary bacterial invasion."
(Lancet 1:87, 1946.)
The value and clinical applications of PAR-PEN, which combines the potent antibacterial action of penicillin with prolonged vasoconstriction, will be immediately apparent to every physician.
Smith, Kline & rrench Laboratories, Philadelphia, Pa.
penicillin-vasoconstrictor combination
par-pen

highest in Michigan ($11.10); lowest in Kansas ($5.85).

Ragweed Campaign Arouses Argument

New York City's vacant lots, and more particularly what grows in them, appear to have an irritating effect on Dr. Morris Fishbein. Not long ago, the JAMA engaged in a lively, if minor, dispute with the city fathers over the habit-forming qualities of marijuana, which addicts have been known to cultivate in Gotham's vacant lots and even in its parks. More recently, the Journal wondered editorially why New York chose to "waste its time" making seasonal attacks on ragweed, bane of the hay fever sufferer, after it had been demonstrated that "permanent riddance of ragweed from any community in which it is well established is well nigh impossible because of the longevity and abundance of viable seeds in the soil." Chicago, Sault Ste. Marie, and Bar Harbor, added the editorial, had destroyed ragweed without accomplishing any reduction of pollen in the air.

Dr. Israel Weinstein, New York's health commissioner, retorted that the journal itself was behind the times, because it referred "to the old method of destroying ragweed by cutting." "We," added Weinstein, "are spraying with 2,4-D, the new chemical that kills ragweed seeds as well as the plant." Furthermore, he said that suburban communities for fifty miles around were cooperating, so that pollen from their areas would not blow into New York.

Dr. Weinstein admitted that ragweed seeds might live as long as

forty years in the soil, but if they did not sprout, no pollen would be produced. The city, he said, in addition to its chemical attack, was considering the planting of grass, white and yellow clover, and Japanese honeysuckle in all open areas in an effort to crowd ragweed out of existence.

The chemical, 2,4-D, was described as economical as well as effective. A pound, which costs $1.10, makes 100 gallons of solution; about six gallons are required to kill 1,000 square feet of ragweed.

Phony Doctor Deceives M.D.'s, Hospital

"I have learned all I know about medicine by observation and by reading medical books. I can't see why doctors need to spend so much time in school." This was the opinion expressed by "Dr." Howard Leslie, 25, of Detroit, when he was arrested recently after posing successfully for eight months as a physician and Army major. During that time he "practiced" undetected in a Windsor, Ont., hospital, and delivered six children in Flint.

After working in the hospital (where he assisted at major operations, but never performed any major surgery himself) Groves took over the practice of an ill physician to whom he had presented forged credentials. Then he began to issue the narcotic prescriptions which quickly brought about his downfall.

"No one ever questioned me about my medical or military claims," Groves told the Detroit Free Press. "I guess if you have enough guts to pass yourself off as a doctor, medical men will take you

at your word. They figure you'll expose yourself soon enough."

Large Field Seen For G.P. in Psychiatry

General practitioners must shoulder a large part of the burden of psychiatric care if the nation is to meet the challenge presented by emotional and mental disorders among the population, declares Gen. William Menninger, former director of the neuropsychiatry consultants division, Army Service Forces. Urging the public to take their emotional problems to the G.P., the general recently pointed out in The New York Times that there are only about 3,500 psychiatrists in the U.S., "including all those who call themselves such regardless of the adequacy of their training or experience."

Since there aren't enough qualified men to handle all cases, said General Menninger, "it is through the general practitioners that we must hope for greater use of psychiatric treatment methods in illnesses of the average man. Many physicians and specialists are quite competent to treat the great majority of the minor emotional difficulties."

The general admitted, "To our surprise, and to our detriment, we discovered that many of our medical officers, particularly the younger men, were not sufficiently grounded in a knowledge of the emotional factors in illness to know the most effective methods of handling them." General Menninger attributed this lack to inadequate psy-

chiatric training in medical schools. Declaring that students devote less than 5 per cent of their time to the study of this phase of medicine, he said: "The result is that many physicians feel quite insecure in their management of the individual who has nervous indigestion or whose functional heart disorder is related to some buried resentment. They feel even less secure in their understanding of fear or anxiety or depression."

The general practitioner will always be "*the* physician," regardless of trend toward specialism, General Menninger believes. "He knows about the whole family and often follows each member from birth to death. Because of his intimate contact he is intuitively more likely to recognize emotional disorders in illness. We must look to him and the non-psychiatric specialists to handle the 'minor' personality disorders; we can look to the psychiatrist for help in the more difficult problems."

"There is a brighter side to the situation," said the general, "to be found particularly among younger physicians in the growing awareness of the need for better training." He explained that many medical schools are improving their teaching of psychiatry, and that training is given in a number of medical and surgical wards and in some outpatient clinics of general hospitals rather than in state institutions or "psychopathic wards."

Calls Health "Individual Responsibility"

Irked by propaganda for compulsory national health insurance, Frank Brown of Elmhurst, Ill., decided to have his say. In a letter to the Christian Science Monitor, he expounded an old-fashioned American conviction:

"Health is an individual responsibility and should cause men and women to safeguard it individually and to reap the benefits of health-giving practices. But to attempt to make it a collective business in which a person can abuse his health, and believe that someone else is going to pay for it, is a very sure way to encourage more abuse and more ill health, and thereby increase the nation's problem.

"It would be just as sensible to make a law taxing everyone in order to provide release from debt for those who squander their money instead of spending it wisely."

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73% BENEFITED

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Formic Acid	*5 mg.*
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Descriptive clinical literature will be furnished upon request.

If your dealer cannot supply you, order direct. 1 cc. Ampuls—12 for $3.50; 25 for $6.25; 100 for $20.00.

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